Report of the Small Business Advocacy Review Panel on OSHA's Potential Standard for Prevention of Workplace Violence in Healthcare and Social Assistance

May 1, 2023

Table of Contents

1. Introduction

This report has been developed by the Small Business Advocacy Review Panel (Panel) for the Occupational Safety and Health Administration's (OSHA's) potential standard for Prevention of Workplace Violence in Healthcare and Social Assistance. The Panel included representatives from OSHA, the Department of Labor's Office of the Assistant Secretary for Policy and Office of the Solicitor, the Small Business Administration's Office of Advocacy, and the Office of Information and Regulatory Affairs of the Office of Management and Budget.

On March 1 2023, Panel Chairperson, Jessica Stone of OSHA, convened the Panel under Section 609(b) of the Regulatory Flexibility Act as amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA) (5 U.S.C. 601 *et seq.*). The Panel identified small entity representatives (SERs) from the healthcare and social assistance sector covered by the draft scope of OSHA's potential standard, as well as from industries that could be brought within the scope of the potential standard OSHA is considering. The SERs reviewed background materials related to this potential standard and offered their advice and recommendations to the Panel. The Panel is deeply appreciative of the SERs for taking the time to assist the Panel in better understanding the potential impact that a Workplace Violence Prevention standard might have on small entities in the healthcare and social assistance sector.

The body of this report consists of four parts:

- Part 1 is the introduction;
- Part 2 explains why OSHA is considering a potential standard for Prevention of Workplace Violence in Healthcare and Social Assistance;
- Part 3 summarizes the oral and written comments received from the SERs;
- Part 4 presents the Panel's findings and recommendations;
- Appendix A contains a full list of the Panel members and staff representatives from OSHA, the Department of Labor's Office of the Assistant Secretary for Policy and Office of the Solicitor, the Small Business Administration's Office of

Advocacy, and the Office of Information and Regulatory Affairs of the Office of Management and Budget;

- Appendix B contains a list of the SERs;
- Appendix C includes all written comments submitted by SERs; and
- Appendix D contains the Preliminary Initial Regulatory Flexibility Analysis (PIRFA) and the Issues Document sent to the SERs.

2. Reasons Why Action is Being Considered

Workplace violence (WPV) against employees in the healthcare and social assistance sector is a serious concern. The Healthcare and Social Assistance sector (NAICS 62) is comprised of 20.9 million employees and is a major component of the U.S. economy. These workers face an increased risk of WPV—nearly six times that of workers in all other industries averaged—resulting primarily from violent behavior of patients, clients, residents, or visitors in their workplaces. OSHA has also heard first-hand accounts of the extent and severity of WPV in the healthcare and social assistance sector, including during a WPV Stakeholder Meeting convened at the Department of Labor in January 2017, where OSHA heard testimony from multiple workers detailing violent assaults that they or their colleagues had endured from agitated patients. Severe WPV incidents have also received attention in the media. Further, while all of this data and these personal accounts indicate that WPV is significantly worse for workers in healthcare and social assistance than for workers in other industries, that data may still obscure the significance of the risks due to underreporting.

This draft regulatory framework is based on many years of agency research, interagency and stakeholder engagement, and trends in WPV incidents in healthcare and social assistance as observed through OSHA enforcement of the General Duty Clause. OSHA currently enforces Section 5(a)(1) of the OSH Act, 29 U.S.C. § 654(a)(1), against employers that expose their workers to the recognized WPV hazard. Also known as the General Duty Clause, Section 5(a)(1) requires that "Each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his

employees." OSHA decided to consider rulemaking after finding such enforcement under the General Duty Clause, as well as its current non-mandatory guidance, are inadequate to substantially reduce the risk of WPV facing employees in the healthcare and social assistance sector.

OSHA has long considered the appropriateness of regulatory action to address WPV. OSHA has also received recommendations to issue a rule on WPV in the healthcare and social assistance sector. For instance, in the U.S. Government Accountability Office's (GAO's) 2016 report "Workplace Safety and Health: Additional Efforts Needed to Help Protect Healthcare Workers from Workplace Violence," GAO recommended that OSHA consider whether additional action, such as developing a standard, is needed. In 2016, OSHA published a Request for Information (RFI) Preventing Workplace Violence in Healthcare and Social Assistance. Prevention of Workplace Violence in Healthcare and Social Assistance, 81 Fed. Reg. 88147 (Dec. 7, 2016). OSHA received over 150 comments from the public in response to the RFI. Overall, OSHA received strong support for proceeding with the rulemaking process.

OSHA's draft regulatory framework addresses, and aims to reduce, the prevalence and the severity of WPV in the healthcare and social assistance sector. For this potential standard, OSHA focuses solely on type II WPV, which are violent acts committed by patients, clients, and visitors upon workers. Some recognized risk factors for WPV in healthcare and social assistance, which OSHA aims to address in this potential rulemaking, include:

- Direct patient care;
- Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff;
- Poor environmental design of the workplace that may block employees' vision or interfere with their escape from a violent incident;
- Lack of means of emergency communication;
- Inadequate security;

- Unrestricted movement of the public in clinics and hospitals; and
- Working alone in a facility or in patients' homes.

As discussed at length in the Preliminary Initial Regulatory Flexibility Analysis (PIRFA), to address such risk factors, OSHA sought to use a programmatic, performance-based approach, rooted in the five core components of a WPV prevention program that are identified in OSHA's existing *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (OSHA Publication 3148) with a series of provisions that would require employers to develop and implement WPV prevention policies and involve employees in the creation and implementation of a workplace violence prevention program.

Figure-1 displays the annual number and rate of WPV injuries for the industries in OSHA's contemplated scope as reported by BLS Tables R-4 and R-8 for 2019. Note that these injuries can be significant and often require many days away from work—ranging from 1 to over 180 days. The average of the median number of days away from work for each injury is 14 days (BLS Special Run Data - Number, median days away from work and relative standard errors of occupational injuries and illnesses involving days away from work in healthcare and social assistance from violence by industry, occupation, and source for All United States, 2019).

Figure-1
Annual Number and Rate of WPV Injuries for Industry Sectors in the Contemplated Scope, 2019

Sector	NAICS	Industry	Injuries	Rate per 10,000 FTE
General hospitals, incl. emergency departments	622000	Hospitals	7,160	17.8
Behavioral Health	622200	Psychiatric and substance abuse hospitals	1,600	152
	623200	Residential behavioral health facilities	3,120	58.2
	621112	Offices of Physicians, Mental Health Specialists	130	26.6
Residential care facilities	623100	Nursing care facilities	780	19.1
	623300	Continuing care retirement communities and assisted living facilities for the elderly	3,280	14.4
Home healthcare	621600	Home healthcare	520	6.1
Emergency medical services	621910	Ambulance Services	260	18.6
Social assistance services		Individual and Family Services	300	20.5
	624200	Community Food and Housing, and Emergency and Other Relief Services	140	8.9
	624300	Vocational Rehabilitation Services	530	21.8

Source: BLS, Survey of Occupational Injuries and Illnesses, Tables R4, R8, 2019.

The literature on WPV includes a number of surveys of healthcare and social assistance workers, which are useful for understanding the prevalence of WPV. Surveys of healthcare and social assistance workers are especially useful in accurately characterizing the extent of WPV, particularly because underreporting of WPV incidents is especially prevalent in the healthcare and social assistance sector.

Summary of SER Comments

The Panel hosted five conference calls on March 14th, 15th, 16th, 21st, and 22nd, 2023 to obtain input from the SERs on OSHA's draft regulatory framework for a potential Prevention of Workplace Violence in Healthcare and Social Assistance standard. The SERs that participated in the SBREFA process represented a diverse range of healthcare and social assistance providers, including some that operate as small entities based on SBA-defined small entity size standards, as well as other larger employers that qualified as small entities under the Regulatory Flexibility Act definitions of non-profit entities. SERs represented industries including hospitals (and entire non-profit hospital systems), addiction recovery and behavioral health services, emergency medical services (EMS) (as well as fire personnel also-trained and performing EMS duties), home healthcare and field-based social assistance services, long-term care/assisted living, and other social assistance providers.

A number of SERs also submitted written comments to the Panel (See Appendix C). OSHA also welcomed and received written comments to the rulemaking record from organizations that were not participants of the SBREFA process but had followed the activity of the Panel. Those comments are part of the rulemaking record and are available to the public in the docket. The following is a summary of the key issues raised during the conference calls and in the written comments from SERs.

Need for a Rule

Because some SERs believe they are already taking adequate measures to comply with existing WPV accreditation, certification, or other requirements, these SERs stated that compliance with a new OSHA rule would result in few or minimal substantive risk-reducing changes in behavior. Some SERs raised concerns that, notwithstanding the overlapping regulations, they anticipated they would incur significant costs under a new OSHA rule because they would need to familiarize themselves with, and review their,

workplace violence (WPV) prevention programs to ensure compliance with the OSHA standard.

Most SERs agreed that WPV is a serious issue in healthcare. One SER said that 18 percent of injuries in their facility that require days away from work, restriction of some duties, or transfer to another position are related to patient behavior. This SER noted that these violent incidents take a large emotional toll on employees, leading to increased turnover, decreased job performance, and increased demand for mental health treatment.

Although many SERs acknowledged that WPV in the healthcare and social assistance industries is a problem, many SERs also questioned the need for an OSHA WPV standard. Many said that they are doing some or most of what was required under the draft regulatory framework, or through their compliance with existing obligations. Many SERs regulated by the Centers for Medicare & Medicaid Services (CMS) conditions of participation, and accredited by the Joint Commission, pointed out that they are required to comply with Joint Commission or other accreditation standards (e.g., Commission on Accreditation of Rehabilitation Facilities (CARF)) for WPV prevention.

SERs who indicated they are already required to implement WPV protections under other requirements also generally said they are currently in compliance with such requirements. Many SERs said they already tracked workplace incidents and some described systems in place with performance targets for preventing WPV. As discussed more below, some SERs questioned the need for a rule based on their belief that existing regulations, guidelines, accreditations and/or certifications already require them to implement a workplace violence prevention plan (WVPP) or other measures to protect workers from WPV.

SERs raised other concerns, including that an OSHA standard would not further reduce WPV, since employers in healthcare and social assistance are already taking adequate measures to comply with other requirements, or would be unduly burdensome, and strain limited resources. One SER representing a non-profit social assistance organization providing housing and addiction recovery support services said that, according to the data that OSHA had provided, this organization should have had one incident every nine years. However, despite this SER having been with the organization for 16 years, the

SER said they could not think of any major issue or physical altercation during that time. This SER also expressed the view that OSHA's contemplated standard would present a significant burden to their organization and said that this would likely come at the expense of the services the organization is able to provide to their served community.

Overlap/Conflict with Other Requirements or Regulations

During the teleconferences, many SERs discussed potential conflicts between OSHA and other regulatory bodies like the Joint Commission and emphasized the need to avoid overlap and excessive regulations. Many SERs told the Panel that the Joint Commission also has requirements for addressing WPV in healthcare settings, and said such requirements have to be followed in order to receive accreditation by the Joint Commission which is a requirement from CMS for receiving Medicare and Medicaid payments. Many SERs indicated that they have some form of certification or accreditation that requires some WPV prevention measures. SERs asked OSHA to consider how compliance with existing accreditation requirements might be considered in determining compliance with an OSHA standard.

Some SERs pointed out specific conflicts or differences between OSHA's draft standard and other WPV requirements. One SER said that the Joint Commission has a different definition of WPV and additional tracking and reporting requirements, but that OSHA has some more stringent requirements in other areas.

In written comments, a SER who represented the home healthcare field elaborated on concerns voiced in the teleconferences over potentially overlapping and duplicative existing standards:

> Within the healthcare industry the term "home healthcare" is generally used to described Medicare certified Home Health Agencies (HHAs). The [PIRFA package] references a number of related workflows to HHAs, such as OASIS assessments. However, HHAs are not the only healthcare providers rendering care in the home environment. Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) companies, home infusion agencies, house-call physician practices, mobile integrated health providers, community health workers, private duty/home support agencies and other transportation or community-based services are not

> presented in the regulatory text. It is not clear whether the regulatory standards would apply to these agency types based on the language and definition of "home healthcare agencies" provided by OSHA. While [our organization] appreciates OSHA's effort to include HHAs and consider the needs of this vital section of healthcare, if this text were presented in a proposed rule, there would be immense confusion in the healthcare and community service industry and large differences in safety standards between various provider types.

The SER representing the home healthcare setting recommended that OSHA "reconsider the scope of the [draft] regulatory text" and devote attention to understanding the range of home-based provider services and the appropriate calibration of mandatory requirements.

Some SERs acknowledged their existing certifications or accreditations may not include certain elements that OSHA contemplates including in a WPV standard, like specific control measures, requirements for violent incident investigation, or specific recordkeeping requirements.

Flexibility and One-Size-Fits-All

SERs almost universally expressed concerns that a potential WPV rule would attempt a one-size-fits-all approach that would be difficult for regulated entities to comply with. SERs repeatedly told the Panel that the difference between types of entities should be reflected in the requirements included in a proposed rule and that OSHA should provide as much flexibility as possible. SERs thought this flexibility was necessary to allow them to address the hazard of WPV in their facility in a way that is most effective for their particular setting while being sensitive to the needs of the population they served. SERs said that it was important for any potential rule to not be too prescriptive since it might result in requirements to implement approaches that are ultimately found to be ineffective at addressing WPV while stifling employers' ability to try innovative approaches that might be more effective. While SERs overwhelmingly wanted flexibility, some SERs also reminded the Panel that this kind of approach can sometimes make it difficult for

small entities to determine exactly what they need to do to comply with an OSHA standard.

SERs generally agreed that a one-size-fits-all approach would not be effective and that a flexible, "performance-oriented" standard allowing for varying approaches to program implementation would be more appropriate. SERs indicated that a standard should account for variables such as clientele served and the employer's operational model. Specific areas of OSHA's draft standard where SERs indicated that flexibility should be emphasized, discussed further below, included metrics for hazard assessment and determination of high-risk service areas and employee training.

However, some SERs expressed concern that, with too much flexibility, OSHA might inconsistently enforce a standard that leaves much up to interpretation of both the regulated community and the enforcement officials. For example, one SER representing a hospital noted that there are foundational elements for all WPV programs, like the written plan, hazard assessment, training, and recordkeeping. That SER wanted to see the regulation be fairly broad and not too prescriptive so that the potentially regulated community has flexibility within a framework of those elements. But the same SER said OSHA would need to have clear direction so that the requirements would not be misinterpreted during enforcement. Another SER representing a social assistance organization said that OSHA should give its compliance safety and health officers enough guidance to ensure that they know what they are looking for during an OSHA inspection.

SERs generally did not approve of having the same requirements for social assistance settings as for healthcare settings. For example, two SERs representing a non-profit social assistance organization noted that a food bank has quite different needs in terms of preventing WPV from, for example, a home healthcare setting. These SERs emphasized that OSHA might be contemplating something that would be appropriate for a healthcare establishment but might be inappropriate or even detrimental for other sectors in OSHA's contemplated scope.

A SER representing a hospital system told the Panel that implementing the Baldridge criteria was "probably the best investment" their organization ever made because the

criteria are adaptable to the internal culture of the local healthcare services. It was described that implementing specific performance excellence criteria (specifically, the National Institute of Standards and Technology's "Baldridge Health Care Criteria") was instrumental in organizational improvement.[1] The cost-efficient benefits of implementing these criteria, which were viewed as flexible and easily tailored to the needs of different organizations, were juxtaposed against the potential financial strain of mandates that lack flexibility and performance goals.

Recordkeeping

Most SERs who weighed in on the topic objected to OSHA requiring employers to document WPV incidents, beyond complying with OSHA's existing requirements for recordkeeping that apply to all industries. Although most SERs reported that they already documented incidents in their facility, they generally thought that additional documentation requirements in an OSHA WPV standard would be costly and duplicative. Some of the objection to the recordkeeping requirements may have stemmed from what the SERs saw as an overly broad definition of what was a WPV incident that would need to be recorded or a concern that OSHA would require a specific form or template for recording incidents.

Many SERs discussed the importance of clear definitions, tracking, and categorizing incidents of WPV with respect to any recordkeeping obligations in an OSHA standard. Many SERs were concerned that including requirements for recordkeeping would be overly burdensome, and some disagreed with the inclusion of requirements in an OSHA standard for keeping a log of violent incidents. However, nearly all SERs that commented on this issue said that they tracked incidents internally and wanted their staff to report incidents. Most SERs indicated that reporting of incidents was important for allowing an employer to keep track of such incidents and trends. Among SERs who spoke on the issue, some reported having internal platforms or reporting systems. One SER

[1] More information on the Baldridge Performance Excellence Program is available on NIST's website at https://www.nist.gov/baldrige.

representing a home healthcare agency said that field staff complete a questionnaire about their shift before signing out, where they report any events or incidents that took place during the shift.

One concern many SERs raised was that staff felt that violence was part of the job, and that some staff may feel reticent about reporting WPV incidents. Some SERs said that staff sometimes do not want to take the time to fill out incident reports especially if they are finishing a long shift and want to leave. One SER said that they offer anonymous reporting which they found has been "tremendously helpful." SERs acknowledged that WPV incidents are underreported in healthcare. One SER cited an International Association for Healthcare Security and Safety (IAHSS) study that found that annually there are about seventeen incidents of violence per one hundred beds in healthcare settings.

A SER who is the president and CEO of an organization that manages home health and residential service agencies discussed progress that organization has experienced due to reporting and recording WPV incidents throughout their health network. However, that SER also expressed concerns about the resources needed to undertake all elements of a WPV program and reiterated those concerns later in written comments:

> [The home services group] has made investments into technical workflow improvements in its electronic medical record to improve communication across disciplines and teams in the organization, developed and deployed training for field employees, and is dedicating support to positions in the organization to advance workplace safety efforts. These investments and the work involved have been complex, challenging, and have added financial hardships. [The home services group] is able to perform these tasks given it is a member of an integrated academic health system that has enhanced resources and institutional expertise to conduct these efforts. [The home services group] is concerned given the difficulty it has experienced that the home health industry is woefully under-resourced to adopt the proposed regulatory text standards. OSHA's one size fits all approach largely ignores the uncontrolled environment that agencies delivering care in the home and community face, as well as the corresponding unique logistics and management that support the care. [The home services group] recommends that OSHA not apply the drafted workplace violence standards to home health care agencies and instead

review the findings of the Taskforce to develop flexible, evidence-based standards that promote safety across all home-based provider types.

One SER told the Panel that the only official recordkeeping they maintain is an OSHA 300 form for a reportable injury. This SER said that every reported incident is discussed and charted as a resident or behavior issue so that the issue can be addressed by a doctor and the resident may be treated by other in-house service providers (i.e., they may be offered a psychiatric evaluation).

Workplace Violence Incident Investigation and Follow-Up

SERs shared different approaches to conducting incident investigations and follow-up. Some SERs were concerned that OSHA requirements to investigate every WPV incident or to investigate an incident within 24 hours were too prescriptive, resource-intensive, or otherwise impractical considering that WPV was broadly defined in the draft regulatory framework to include threats and near misses. Several SERs shared that they only investigate WPV incidents resulting in physical harm.

A SER reported that, in their facility, the intranet includes information to educate and encourage reporting of incidents. The employer also uses a follow-up reporting system that documents the incident and response actions to mitigate the cause. For post-incident follow-up, managers and sometimes security are involved. The SER said that for incidents with minor or no injury, a manager files a report that includes mitigation steps taken and support services offered to the victim, which is a relatively quick process. However, the SER said, if there is a significant injury, a root cause investigation is conducted and reviewed by the in-house WPV committee, which can take up to a month. The SER said that the committee reviews incidents in facilities in other jurisdictions to determine how they would respond and to help identify gaps. This SER said that their facility offers post-incident support for victims.

A SER representing a disaster response organization shared that their organization has employees fill out a serious incident report if they encounter a hazardous situation. This SER said they try to review and improve their processes and that they track and review

incidents but cannot always implement desired measures, as they may be cost-prohibitive.

A SER mentioned that incidence response is already defined by the Joint Commission, and some recordkeeping is also already required by the Joint Commission and OSHA. This SER said that they do not conduct a root cause analysis for every single WPV incident because they do not have the resources to do so, but they will conduct a root cause analysis if the incident meets OSHA's reporting criteria. The SER said that a root cause analysis can take a month or two. Another SER told the Panel that they conduct only a couple of post-incident investigations each year because they only investigate incidents that resulted in physical harm.

A SER said that, as a smaller hospital, they do not have a risk management department. This SER said they use an incident reporting mechanism and will only do root cause analysis of incidents that resulted in serious harm. This SER reminded the Panel that the costs add up between personnel, software for tracking and reporting, and time required. This SER thought it was too prescriptive for OSHA to require investigation for every incident or near miss and shared that incidents happen daily especially if threats are included in what is considered a WPV incident.

A SER said that their incident investigations involve the victim, the program director, and the person they directly report to. In this investigation they review the clinical record, look for and identify any outstanding alarms that were missed, and decide if current policy or practice needs to be updated. The SER said that these reviews take about one hour.

Another SER told the Panel that a requirement to follow up on an incident within 24 hours would be incredibly difficult due to the number of incidents. This SER also felt that it was better to wait "two sleep cycles" (48 hours) to go over the incident because revisiting the incident with the victim sooner could cause additional trauma.

One SER, representing a multi-hospital health network, submitted extensive written comments on OSHA's draft provisions addressing WPV incident investigations:

> OSHA seeks to require a "root-cause" analysis for all workplace violence incidents, which includes threats and "near-misses." This requirement is not only overly burdensome, but also difficult for us to comply with as threats and near-misses are subjective and vary from employee to employee. In addition, the requirement for employees to report all "threats" and "near misses" would congest us with reports, leaving little resources to handle actual threats of violence.
>
> Further, to identify the "root-cause" of each incident, we would need to "document the significant contributing factors of workplace violence incidents and any recommendations received, and corrective measures decided upon and taken." (OSHA's Prevention Document, 88). [SER's health system] would need to hire a team of investigators who would only interview staff on alleged threats and near-misses. Not only would this consume valuable staff resources and time, it would pull staff away from patient care.
>
> Instead of requiring employers to complete an exercise with little added value, OSHA should only require a "root-cause" analysis when a reportable injury occurs (loss of eye, hospitalization, loss of limb, etc.). A general investigation, as defined by hospital policy should occur in all other workplace violence encounters involving injury. Such requirement would be narrow in scope, more feasible and practical, and would provide the employer with actionable information which may prevent future acts of workplace violence.

Another SER, a certified resource manager of a critical access hospital, recognized the value of incident investigations but cautioned the Panel to limit the burden on smaller operations by avoiding (1) overly prescriptive requirements for methodologies such as root cause analysis and (2) low thresholds for the type of incidents that qualify for investigation.

Post-Incident Support

Several SERs discussed the need for mental health support for employees who had experienced WPV, the potential impacts on workers' compensation costs, and the difficulty of determining work-related stress. Many SERs felt it was important for OSHA to include some requirements for post-incident support for employees who are victims of violent incidents at work. A number of SERs detailed their programs and approaches for addressing employees' post-incident needs.

At least two SERs stated that they have an employee assistance program (EAP) that employees can access for support. These SERs said that post-incident debriefing is particularly important, as is providing time to step away from work.

One SER detailed the post-incident support at their facility, telling the Panel that they offer peer-to-peer support, stress management services through their chaplains, and an employee wellness team that provides access to free licensed counselors, a team health plan that offers six free counseling visits, access to mental health crisis clinics, and a wellness program that offers support to employees who are caregivers. The SER said that this mirrors the benefits available through a workers' compensation program.

Another SER agreed that OSHA should include some element of employee support in a potential rule; however, the SER also believed it would result in operational challenges related to backfilling the role to allow the victim employee time to decompress. At their facility, this SER said they have had instances where the event was so traumatic that occupational therapy suggested the employee take time off. However, they had difficulty getting approval for workers' compensation to cover this.

One SER said that all information about each incident of WPV— verbal or physical— automatically goes to a clinical incident response team. This SER reported that staff have responded positively to having someone from the wellbeing group follow up to see how they are doing.

Staffing Concerns

Several SERs raised staffing concerns within the healthcare industry. These concerns included low staffing levels, with at least one SER stating that staffing for EMS is at "critically low" levels. One SER mentioned that turnover is high in the healthcare industry, and that many employees are no longer employed at their facility after three years.

Some SERs also mentioned the challenges that staffing levels pose to employee safety and well-being. Some SERs acknowledged that WPV risks were higher when there is inadequate staffing.

At least one SER expressed concerns that compliance with the rule could also exacerbate staffing issues by requiring too much of staff time for compliance or lead to staff leaving.

Correctional Health Settings

SERs who provided healthcare services in correctional settings told the Panel that they did not think an OSHA standard addressing WPV in correctional healthcare settings was necessary. These SERs said that the healthcare settings in correctional facilities were already highly-restricted settings in which patient and personnel access and movement were tightly controlled, and that measures to mitigate and respond to violent incidents were already fully implemented. OSHA had not included healthcare settings in correctional facilities as part of the main scope of the draft regulatory framework but had considered whether to include these settings in a regulatory option.

One SER with experience providing healthcare services to correctional settings recommended that OSHA's rule not cover such entities since correctional settings are already highly regulated. The SER said that everyone needs to be approved to enter the facility and that there are strict rules about what can be brought in. The SER told the Panel that, in these settings, staff are never alone and that there are doors, locks, physical barriers, and correctional officers on hand to assist with volatile situations. This SER also stated their view that an OSHA rule would not provide more safety.

Another SER representing some services to correctional facilities told the Panel that employees in correctional healthcare settings located within correctional facilities have very limited control over physical barriers because those are determined by the state or county. This SER said that, in these settings, alarms and panic buttons are very common. When asked, this same SER recommended that OSHA's potential rule not include correctional facilities. In addition to potential conflicts with other requirements already imposed on these kinds of facilities, the SER said that these kinds of facilities have a

higher rate of incidents, but that movement is so highly controlled and restricted, that it is questionable whether an additional layer of regulation would make a difference.

A third SER reported that they have a correctional unit within their larger healthcare facility and told the Panel that the State Department of Corrections maintains security to get in and out of that unit. They said that, to access the unit, a person must pass through a locked area and give up anything that could be considered a weapon. This SER told the Panel that the unit is fully controlled by corrections officers, that two officers are assigned to each patient, and that more officers are present to open doors and assist in relocating the patient when necessary.

These three SERs all reported that staff working in these areas receive de-escalation training and that some receive other training like post-incident training, reporting training, or WPV protection training. One SER said that training varied by state and another SER said that staff receive additional training provided by that state's Department of Corrections.

Field-Based Care

SERs representing EMS and home healthcare provided insight on the measures they currently take to prevent WPV in their organizations. Some SERs also recommended that EMS and home healthcare be addressed separately from other settings.

One SER told the Panel that the recommended WPV controls appear to not fit with the disaster response model as there are no fixed work sites; sites are based on where a disaster occurs. This SER thought it would be costly to implement such measures at variable disaster sites.

Another SER, who was the chief of a fire and EMS organization, discussed the difficulties of conducting workplace assessments from the standpoint of a WPV program for transport and other mobile services where the scenarios are unpredictable and can evolve rapidly. The SER explained that an emergency medical call to a residence can turn violent through tense interactions with patients or family members. Similarly, the SER

said that a motor vehicle accident that leads to two combative drivers must be resolved by the EMS team. That SER described how EMS directors look at known assessments and meet with staff to ask what could be done better to protect all affected parties.

One SER representing an emergency response organization told the Panel that their workforce has to respond wherever something is happening and that EMS providers work in threatening environments and respond to situations where violence is occurring. This SER said that their organization is highly integrated with and dependent on law enforcement, and employees from the SER's organization often respond to scenes with law enforcement. As a result, the SER and their employees do not always have independence in determining how to respond to violence. This SER said that any regulation must recognize that, in some cases, the regulated entities cannot control the entire situation. In addition, the SER detailed the process of responding to and assessing hazards in emergency response situations. The SER explained that the controls begin with 911 when a call comes in; 911 operators assess the safety of the situation and have databases they can reference that flag any history that responders need to be aware of (e.g., if firearms are in home). The SER said that their responders must wait for law enforcement if they are told that they must enter with law enforcement. The same SER also described training they provided to employees on approaching patients in the field. (See discussion of SER comments on Training below.)

Another SER mentioned that their EMS responders have panic buttons on their radios that alert the dispatcher if there is an emergency.

One SER representing a disaster response organization said that they did not have data on incidents of violence against workers in their response operations. This SER said that sometimes there is violence between individuals the organization is serving. They also said that staff and volunteers receive training and that they have personnel on location to assist with security and asset protection and who liaise with law enforcement.

Some SERs representing home healthcare providers discussed their experiences using check-in/check-out systems and joint visits (more than one staff) for staff safety. Some SERs said, when their employees visit homes, the employees use technology like wearable panic buttons and app-based tools that are used to identify hazards in each

individual environment. Another SER mentioned that home healthcare nurses have tracking and panic buttons that can alert control center and authorities. That same SER also told the Panel that home healthcare nurses sometimes go with a driver (e.g., due to neighborhood risks).

Hazard Assessment: Conducting Hazard Assessments, the Definition of High-Risk Service Areas, the Definition of Workplace Violence Incidents, and Previously Unreported Incident Review

Conducting Hazard Assessments

Some SERs provided feedback about their current hazard assessment practices, and some SERs raised concerns about OSHA's requirement to do hazard assessments as part of a WVPP.

One SER representing a community health system mentioned that their organization uses a specific assessment tool to identify community health needs in their served region to assess hazards and vulnerabilities among provider establishments.

One SER said that they felt that the mandated, prescribed reviews of policies, such as what OSHA's hazard assessment contemplates, would become a time when managers come together and "rubber stamp" everything. This SER felt it was a hassle, that some people did not even look at or edit the written policies or programs, and that it would be more impactful if things were reviewed on an "as needed" basis when issues arise. Another SER discussed their process, explaining that they do annual physical security assessments that involve interviewing unit directors or leaders and compiling that information for a report. The report is reviewed and—if budgets allow—adjustments are made.

The director of environment, health, and safety for a hospital described a successful strategy for reducing the incidence of violence using employee records. In the hospital's recordkeeping strategy, employees with recurrent involvement with WPV incidents were identified through a tracking system and provided retraining. This SER said that they have a particularly good electronic medical record system where reports can be pulled,

and they have noticed that a lot of their incidents were occurring with the same employees. It was not necessarily a patient repeating a situation—so much as it was a few employees that were struggling with their interactions—how they approach people. This SER noted that his organization has noticed that, with a bit more training on how to approach people, de-escalate situations, and respond, this organization has seen a good deal of success in reducing incidents.

Some other SERs objected to the regulatory framework requirement that involved looking back at three years of previous incidents to determine whether their establishment (or area of their establishment) was a high-risk service area. One SER requested that OSHA (or other authorities) provide hazard assessment guidance to assist smaller social assistance enterprises.

The Definition of High-Risk Service Areas

Many SERs objected to OSHA's draft definition for "High-Risk Service Area" which defined service areas with one WPV incident every three years as "high risk" for the purposes of the standard's requirements. Many SERs said that under this definition every part of their facility would be considered a high-risk service area. Many SERs questioned the practical utility of the draft definition for high-risk service areas that could require heighted protective measures for the majority of the facility. Some SERs advocated for a "performance-based" or more flexible approach to the identification of high-risk service areas than contemplated by OSHA's draft definition. For example, some SERs suggested an approach that would involve comparing the incident history, frequency of incidents, or other risk or data metrics within a facility, organization, or sector of the healthcare industry, to evaluate relative risk within the facility or industry and focus on areas with the most risk.

SERs did not have a clear suggestion on what should trigger an area to be considered a high-risk service area but many SERs thought it would be impractical for OSHA to declare that a certain number of incidents meant a location was a high-risk service area. One SER pointed out that there is "no magical number" of incidents that would trigger the classification but instead said organizations need to watch and assess. Several SERs

told the Panel that organizations should have the flexibility to identify high-risk service areas based on their own assessments.

SERs described many factors that they consider when determining risk. SERs said that internal data are important in determining whether an area should be considered high risk. A SER mentioned that their organization had developed an internal tool for evaluating risk based on OSHA's guidance. Another SER said they consider internal data and facility-based incidence rates alongside other factors to determine risk.

Some SERs pointed to other variables, besides past incidents of violence, which might put certain employees at greater risk. For example, a SER mentioned that in some circumstances, level of risk was defined based on an employee's occupation and not necessarily the hospital unit they worked in. Another SER shared their facility has a grievance officer who meets with upset clients and that this individual may be at elevated risk for WPV even though this position is not defined as a patient contact occupation. Another SER said that there were particular clinical diagnoses where patients present a higher danger to staff.

Many SERs mentioned that emergency rooms and intensive care units were generally considered high risk, and many SERs whose facilities had them reported that in-patient psychiatric treatment areas and locked correctional units were also always considered high-risk service areas. Another SER added that pediatric intensive care and labor and delivery units were considered high risk in their facility. SERs who served populations with dementia, Alzheimer's, and substance use disorders also mentioned that areas dedicated to treating those populations were generally considered high-risk service areas. A few SERs suggested that OSHA should consider covering pharmacies as high-risk service areas. One SER told the Panel that they had an incident where someone showed up to the pharmacy demanding opioids, and another SER recalled an event where an individual drove their car into a retail pharmacy to try to obtain prescription drugs.

A SER representing a behavioral healthcare facility reminded the Panel that behavioral health facilities are not all equal and suggested it would be appropriate to stratify the risk level by the acuity of care. This SER said that detox facilities may have a higher risk than other types of facilities and mentioned that some treatment programs allow mental health

patients while others do not, which might result in a higher level of risk. This SER also said that facilities differ significantly based on whether they are private or public. Public behavioral health providers may be required to accept patients, regardless of if they are a threat, while private behavioral health providers may be able to turn those patients away.

Some SERs said that allowing flexibility in defining high-risk would benefit employers. For example, one SER said that this would allow employers to prioritize and focus resources on areas most in need. Another SER described their organization's practice for addressing WPV; this SER told the Panel that every year, they focus on a number (e.g., two or three) of the highest-risk areas in their facility that they have identified based on their internal data and develop procedures to reduce the risk for those areas. This SER said that hopefully the WPV incidents decrease in those areas and different areas can be focused on in subsequent years.

Another SER questioned whether facilities would face scrutiny if they have an incident in an area they deemed as low risk. Another SER, overseeing system safety, security, and emergency planning for a network of hospitals, echoed similar views on OSHA's definition for high-risk service areas, stating that high-risk must be specific to a particular environment and timeframe as judged by the facility. There should not be a fixed metric for high-risk, that SER said.

Some SERs also raised concerns about the cost impact of too broad of a definition for high-risk service areas. For example, a SER representing a multi-hospital health network said OSHA's draft definition of high-risk service areas was too broad and would likely lead many healthcare facilities to stretch resources to implement abatement methods that would compromise patient care. That SER elaborated on these points later in written comments:

> If this legislation were to move forward, I propose that "High Risk Service Areas" should be determined based on an annual review of workplace violence records and include *only* the areas which have the highest rates of workplace violence. This would allow organizations to focus its resources on *actual* high-risk areas. By maintaining a broad definition of "High Risk Service Area," OSHA is seemingly prioritizing the issuance of citations over employee safety, as the current definition nearly ensures that

employers will never be in compliance with the vague and over broad standard.

As I explained during the Panel, as a part of most organization's emergency management and preparedness programs, we conduct an annual Hazard Vulnerability Analysis ("HVA"). A HVA and risk assessment is a systematic approach to identifying hazards or risks that are most likely to have an impact on the hospital. We rank the hazards in order of their impact, and work throughout the year preparing for and responding to these top identified hazards. For example, if our top hazard was a surge of injured patients to our emergency room, we would write policies to respond to this event, train our staff on rapid triage and decision making, ensure the proper medical equipment is available and test the plans through a simulated exercise. As our preparedness increases, the risk becomes reduced and is no longer a top hazard. If we take the same approach for workplace violence, we would be able to focus on the areas or departments that are identified as the highest risk and reduce the risk with preventative measures.

The Definition of Workplace Violence Incidents

Many SERs expressed concern that OSHA's definition of WPV incident seemed too broad. SERs indicated that different sectors or entities may use different definitions for WPV incident that can range from verbal altercations and/or threats to physical assault causing injury, with a considerable variety of WPV incidents falling in between. SERs also noted that, for some workplaces, violent verbal threats may be commonplace or daily occurrences, depending on the nature of the patients or clients. Other SERs told the Panel that verbal threats, harassment, or abuse had significant negative effects on employees and were considered violent incidents, that they wanted staff in their facilities to report, and that these should be considered WPV incidents under an OSHA standard. Many SERs raised concerns that defining WPV incident to include verbal threats, when coupled with OSHA's draft definition of high-risk service area, would result in every workplace area being construed as "high risk." Some SERs requested that OSHA clarify the meaning of a WPV incident based on this feedback.

There was not a clear consensus among the SERs on whether verbal threats, intimidation, or harassment should be considered WPV. Some SERs encouraged their staff to report both verbal threats and physical harm. One SER mentioned that their entity would ordinarily collect reports of "near misses." One SER told the Panel that verbal violence can cause lasting harm and mental anguish. Another SER was concerned about potential

legal repercussions if verbal threats were reported. One SER representing a behavioral healthcare provider said that verbal threats are more common in that industry as compared to other healthcare settings. This SER told the Panel that verbal outbursts of some nature are just a part of some behavioral health settings and rarely predict an actual incident of violence in such settings. Another SER said that threats were common from elderly patients with dementia who might regularly threaten staff but are not physically able to carry through. According to this SER, these patients do not pose an actual threat to staff.

Some SERs thought there should be a distinction between intentional and unintentional incidents, but others thought that did not matter. For example, one SER said that that the definition of WPV incident in OSHA's draft standard was too narrow, especially with older adults who have cognitive impairments, and that there are more unintentional incidents with this population that should not be treated in the same manner as intentional actions. The SER thought that an approach distinguishing between intentional and unintentional actions would help with better reporting. Another SER suggested that "intentional" could be described as purposeful motion or movement, while "unintentional" could be actions by persons with cognitive impairment, someone coming out of anesthesia, or behavioral impairment. A third SER said that intent is difficult to define and suggested that maybe criminal intent should be considered in determining what is intentional, and what rises to the level of WPV. Other SERs said that most violence is from hands and feet (e.g., when patients are flailing their limbs) and that when an employee is physically beside a patient, the risk is spitting or striking.

Previously Unreported Incident Review

Some SERs expressed concerns about OSHA's draft requirement that, in order to better inform initial and annual hazard assessments, allowed employee reporting of WPV incidents that had occurred within the prior three years and that had not otherwise already been reported. Some SERs said that after-the-occurrence reporting would not be particularly useful because major incidents (e.g., those resulting in injury) were always recorded and that minor, previously unreported incidents were unlikely to be recalled with enough specificity to conduct a meaningful hazard assessment long after the incident

occurred. Some SERs thought this would be very burdensome and not especially useful because employee memories of WPV incidents would likely decline over time. One SER thought that going back one year may be more helpful for critical injuries (e.g., choking), but still was not sure how useful that information would really be overall. This SER thought this sort of look-back should be a lower priority than other things they already do, and that it would be unduly resource-intensive. This SER also thought a look-back would not be helpful in making a new WPV plan or hazard assessment (i.e., for the first time), as opposed to revising an existing plan.

Engineering/Physical Controls

Many SERs were concerned with OSHA's draft regulatory framework for engineering controls. SERs interpreted OSHA's framework to require numerous engineering controls that they thought would be difficult and costly to implement. Some SERs told the Panel that some engineering controls mentioned in the draft regulatory framework could not be used (e.g., cameras are not allowed in many areas of healthcare facilities for privacy reasons) or would be counter to the standard of care in their facility (e.g., furniture that could not be rearranged in hospice settings, or barriers in memory care areas that might distress patients). SERs representing residential care settings told the Panel that their facilities are intended to be a comfortable, home-like setting and that introducing many of the engineering controls mentioned in the draft regulatory framework would negatively affect that feeling. Many SERs objected to the idea of OSHA requiring any particular engineering control in any particular situation, and they thought it was best to not be too prescriptive and that OSHA should allow employers to determine what is effective for a given location.

SERs shared their experiences with implementing safety and security measures that would constitute engineering or physical controls under OSHA's standard. These include surveillance cameras, alarm systems, and electronic lockdowns, and structural/layout elements within a building. Participants emphasized the importance of customized engineering and physical controls based on the type and location of the facility.

One SER, representing a social assistance provider, reported installing cameras and consulting with the local police who assisted in determining where cameras should be placed. Another SER said they have a panic alarm that notifies police, and that, in addition, one facility has a lockdown button, and they use a paging system, badge access spaces, and protective glass in some areas to further protect employees. A different SER, representing a general hospital, reported having cameras in some areas, keypads, metal detectors, overhead paging systems, panic buttons in psychiatric and emergency departments, and bulletproof screens in some areas. This SER also reported working with protective services to help organize room layout for optimum safety.

A SER also mentioned they create "safer rooms" for behavioral patient populations; the rooms are designed to reduce hazards to staff including by clearing out items or equipment and, when patients are discharged, the room is turned back into a regular room. Another SER said they had safer rooms as well and added that they remove objects that can be thrown and use a "safety observer" to monitor patients who are placed in those rooms. One SER said that employee input for safer rooms is part of a larger cross-campus hazard assessment.

Another SER reported having a paging system for staff. This SER thought alarm systems at workstations were more useful than personal devices like panic alarms because personal devices are misplaced or lost regularly. Another SER said that their local police department does not recommend panic buttons, while other SERs said that panic buttons or alarms were difficult to maintain and may give employees a false sense of security.

One SER told the Panel that metal detectors are obsolete and shared that their facility uses a weapons detection system that detects any item that can be used as weapons like knives, forks, or pepper spray.

A SER reminded the Panel that some engineering controls require additional staffing to use (for example, someone needs to operate a metal detector if a facility has one). Another SER representing a non-profit behavioral health organization told the Panel that they would need to apply for and receive grant funding to implement any engineering controls.

Some SERs raised potential legal concerns about their abilities to implement certain engineering and physical controls. For example, one SER, representing a home healthcare provider, reminded the Panel that an employer cannot put cameras into patients' homes. Another SER, representing a long-term care facility, said that some of the engineering controls cited in the regulatory framework appeared to conflict with resident's rights, and there would be feasibility issues with engineering controls like metal detectors, panic buttons, or plexiglass because residents live at the facility. Another SER raised concerns that installing certain types of alarm systems could violate local building code regulations.

Some SERs who represented residential-type facilities reminded the Panel that they want their facilities to look like homes and not institutions or prisons, and that this makes it difficult to have certain controls in place. For example, one SER representing an organization that provides a variety of services, primarily for elderly clients in the space of home healthcare, long-term care, and social assistance services stated that, especially in their newer facilities, they try to construct a welcoming inviting environment. Even if it may protect their employees, this SER said, putting up plexiglass and making it "look more like check-in for the jail," is not a welcoming environment and is not aesthetically pleasing. This SER said that such controls would conflict with their homelike environment—and that they are regulated around providing patient residential care in a home-like environment. Residents in this SER's organization largely reside in "pods and little communities," and so even line of sight is difficult to achieve, because the intention is to be like a home, and not an institutional setting.

Some SERs told the Panel that, where settings are houses (i.e., transitional housing, housing for individuals with intellectual disabilities) barriers and some other engineering controls are not consistent with their service. Another SER said that protective barriers signal "us-versus-them" to patients and limits the ability to provide caring and nurturing service. Another SER said that sometimes physical barriers are a direct impediment to working with patients and may escalate behaviors because patients feel the need to overcome those barriers to connect with staff. This same SER said that camera systems

have been very effective in deterring incidents in some facilities and in assisting with post-incident evaluation (e.g., what could have been done differently).

One SER, representing a network of long-term care, assisted living, and other home-based health services perceived difficulties in adapting a WPV hospital-based model to residential services, particularly with regard to engineering controls, recordkeeping, and hazard assessment. On controls, that SER discussed potential conflicts with their operational model and stated that metal detectors, panic buttons, and plexiglass barriers are not usually installed in residences.

A SER with a behavioral health unit said that their unit has isolation rooms that patients can enter on their own if they need quiet time, but patients cannot be locked in those rooms because it is considered seclusion that requires a physician's order. This same SER said that they cannot lock doors unless it is in a protective environment because it can be a fire hazard, and they need hardware for bathroom doors to comply with special locking arrangements under the National Fire Protection Agency requirements.

Some SERs expressed concern that having to implement engineering controls would be costly. One SER told the Panel that any physical changes would have to comply with building codes which the SER said would be "hugely expensive." Another SER said that if an OSHA standard required changes to nursing stations, it might cost hospitals millions of dollars and they might not have that money available. One SER representing a disaster response organization said that they cannot implement controls like put up fencing or hiring security guards because it is too costly. This SER also said they try to coordinate with local police, but frequently there are not enough officers for them to do so. This SER said that they implement less costly options where they can (e.g., improved lighting).

Electronic Records and Patient Flagging

SERs explored the possibility of sharing information about patients with a history of aggressive behavior through electronic records, while respecting patient privacy. Some SERs shared that flagging policies to alert staff to patients' conditions helped reduce WPV incidents. Some advocated for cross-employer warnings. One SER said that some

of their units have started to implement the door flag when there is potential for WPV that serves to notify staff regarding the hazard as they are interacting with the patients (or their visitors). This SER reported that this system has had a positive impact. This SER noted they have not implemented medical record flagging yet, but that they have engaged with a lot of other health systems, who have seen positive impacts. The medical record is used as the flag for the clinical staff, but a door flag can let other staff, such as food and nutritional services staff, be aware as well.

One SER shared that tracking past WPV incidents in their medical record system, where they can pull reports for specific patients, was useful. This SER explained that using this system, they had noticed cases where incidents were occurring with the same employees who were struggling with their patient interactions. This also allowed them to better train employees on how to respond to WPV.

Several SERs raised concerns about potential detrimental effects of permanently flagging patient medical records. One SER said it was important to avoid stigmatizing behavioral health patients and to consider difficulties in verbalization for this patient population. This SER said that any potential standard should be sensitive to the behavioral health patient population.

Another SER reminded the Panel that patients come in crisis and the SER did not think that patients should have the subjective flagging of an incident held against them forever, especially for a one-time event. A SER was concerned that the flagging could be viewed by others during, for example, background checks for employment. A different SER wondered how to decide when a flag would go up or down and who should have the ability to add or remove those flags. This SER also wondered if flagged patients would get different or worse treatment from staff and if flagging a near miss or verbal threat would be appropriate.

Another SER agreed and added that flagging patients' medical records creates issues for flagged patients who are seeking placement in other facilities, which are already hard to find and may be further complicated if their record is flagged for previous violent behavior that was the result of a now-treated condition.

A SER representing a multi-hospital health network objected to flagging patients with a history of violent behavior, and the SER submitted written comments following the teleconferences to express concerns:

> First, such requirement [to flag patient records] will inevitably lead to disparate treatment for patients with a history of violence, even if they are not exhibiting any violent tendencies during that specific visit. Such disparate treatment may include, but is not limited to, isolation, reduced visits from nurses, and/or lower quality of healthcare treatment. While employers will do their best to prevent this treatment, employees are likely to engage in these tendencies out of fear. Further, it should be noted that just because a patient engaged in violent behavior during one visit, does not mean the patient will exhibit similar behavior in the future.
>
> Second, the inclusion of an incident of workplace violence (including threats and near misses) in a patient file is subjective and will not be equally applied. Not only will the inclusion of workplace violence incidents in medical files be varied, the patient medical files may also be discoverable (i.e., during unrelated litigation, for job applications, etc.…). This threatens patient confidentiality.
>
> Third, a coding system does not adequately protect a patient's privacy rights. For example, a "color, shape, or icon" code placed on patient's door would signal to everyone, including the public, that the patient at one time may have engaged in workplace violence (as defined by OSHA), or at the very least has a unique condition. Finally, such program is too permanent and does not take into account the transient nature of healthcare.
>
> While an expansive patient tracking system presents a myriad of issues, there is a reasonable compromise: only tracking incidents of violence which resulted in employee injury. This tracking designation would remain private and appear only in a patient's confidential medical records. This would allow any employee treating the patient to have knowledge of the previous incident and take any necessary precautions pursuant to the hospital's policies. The marking or designation should be removed after a set period of time if the patient did not have a further incident of violence.

When expressing support for the flagging process, a SER that oversees system safety, security, and emergency planning for a hospital network described their flag as a temporary notification to all staff when they have an extreme and aggressive incident of WPV. This SER said that they use flagging very rarely (17 out of a total of 2,400 incidents in the past year were flagged) and only for the most egregious of offenses. This

SER shared that a patient is flagged for a minimum of one year after a threat assessment team has reviewed the report of a violent incident and determined that the patient has exhibited extreme and aggressive forms of violence. If, in a year, that individual had a certain number of interactions that did not result in hostile or aggressive behavior, this SER explained that the facility will remove the flag. The SER characterized the process as a benevolent interaction where advanced notification must be provided to caregivers with instructions on intervention strategies. The SER shared that detailed behavioral information and the intervention strategies for dealing with the flagged patient (e.g., two-person nursing, security, arm's length distance) are provided to the care team. This SER clarified that the information is not shared with persons outside the system but noted that their facility sometimes sees flags on electronic records from patients within the region that were treated and flagged in another facility.

Personal Protective Equipment and Other Preventative Measures

Regarding personal protective equipment (PPE), some SERs felt the draft regulatory framework needed more guidance on when PPE would be required and how its use should be implemented. However, one SER from an organization that provides a variety of social assistance and behavioral health services noted that they do have and provide PPE (e.g., bite sleeves). Another SER mentioned how their organization had priced PPE such as bite-resistant shields to be over $100 each, and asked whether such PPE would need to be provided for all workers.

With regard to other measures that could be taken to reduce the risk of WPV, some SERs discussed the importance of customer service (e.g., providing more timely and transparent services in a more inviting atmosphere with reduced wait times and sufficient staff to manage specific requests) in WPV prevention—and some SERs suggested to incorporate this aspect into violence prevention programs. Similarly, another SER said they found that minimizing other stressors in the work environment also helped reduce incidents of WPV; for example, individualized place mats for patients in the dining hall that provide relevant patient needs resulted in one less thing for staff to remember which can help to reduce WPV.

Training

SERs provided a robust discussion around the topic of training. Many SERs recognized the importance of training on WPV. The majority of SERs who commented on the subject of training recognized its value and effectiveness in mitigating WPV and as a key component of a WPV program. Many SERs said that the most effective training programs are flexible and not one-size-fits-all. Several SERs noted that a hybrid approach that includes written materials, video instruction, and interactive live demonstration can be particularly effective. Many also reported that de-escalation training was extremely useful in reducing WPV incidents. Some SERs also told the Panel that the skills necessary to defuse or respond to a WPV incident were most effective when they were practiced or reviewed regularly.

A number of SERs saw the utility of a baseline level of training (anywhere from an hour or so during new employee orientation to as many as eight hours to 24 hours, depending on exposure to risk) for all employees and many SERs reported providing at least an awareness level of WPV training to all employees at their facility. However, many SERs objected to requiring high levels of training for all staff exposed to WPV. SERs expressed concern because OSHA's draft standard contemplated higher levels of training to be tied to the designation of a high-risk service area, which SERs thought would encompass their entire facility under OSHA's draft definition. A number of SERs also expressed concern that it could be costly and wasteful to invest substantial time or money training new employees in positions that experience high turnover.

Many SERs also emphasized the importance of adaptability in training requirements such that the content can be tailored based on patient/client/resident populations and relevant to the specific hazards recognized within an employer's own establishment. Some SERs told the Panel that training requirements should be based on the risk faced by workers as determined by the employer and that OSHA should not say what training must be offered to what employees. Some SERs also said that mandating that workers be trained for a certain number of hours was not an effective approach, since ultimately it is the content and teaching methods that matter more than time spent. Some SERs said that OSHA

should consider existing worker training that is provided in order to comply with other WPV requirements, such as, for example, with Joint Commission accreditation requirements, as meeting the training requirements of any eventual OSHA standard as well.

Many SERs described their existing training programs to OSHA. The programs varied considerably.

One SER told the Panel that employees in emergency departments and behavioral health departments need and receive the greatest amount of training in WPV response. And another SER told the Panel that they evaluate the patient population and nature of events that take place in an area and provide specific training and education to staff based on that. Some SERs said that they track incidents in their facility and increase training of staff if they see an area with increased instances of WPV.

A SER who is chief security officer for a general hospital discussed that their hospital provides additional training on physical intervention—in some cases up to 24 hours of crisis response training—and that their facility found such training necessary even beyond the basic level of other requirements the hospital is already subject to. According to that SER, the number of injuries reportable to OSHA decreased as training increased in that facility, a trend that the SER viewed as a successful application of a comprehensive training program.

Another SER representing a hospital system emphasized the importance of one- to two-day de-escalation training for direct-care professionals and staff throughout the facility. But that SER's hospital system must also sometimes limit the training available to registration clerks, housekeepers, and other staff that OSHA has described as patient contact personnel in the PIRFA package, and this was often because of tight schedule pressures. In addition to training, that SER said the hospitals in that network also rely on monthly meetings, huddles, and extensive use of signage that communicates zero tolerance for violence.

One SER from a hospital setting in California (a state with an OSHA-approved occupational safety and health program that already has a standard for prevention of

WPV in healthcare) noted that, in their experience, training is the hardest component of California's standard to comply with. This SER said that employers do their best, but that training is probably the most expensive and time-consuming to keep up with. This SER stated that it is difficult to schedule 200–300 nurses to be away from their jobs, and this can be challenging for nursing directors to make this work since patient care is the priority. However, this SER also added that it is perhaps the most effective component of California's standard.

A SER in residential healthcare said that their organization's training focuses on mitigating combative and belligerent behavior. That SER described live action training with six attendees learning from an actor who demonstrates techniques for de-escalation of violence.

Another SER, an environment, health, and safety manager for a midwestern-based hospital network, described a two-tiered training programs using two vendors, with de-escalation training provided for the full staff and more specialized training for certain types of high-risk work.

A SER representing EMS services discussed training from that perspective. Because of the unpredictable and evolving nature of the workplace for mobile and transport emergency services, the training for EMS personnel involves developing skills such as maintaining constant awareness of access and egress points, protecting the body in the event of assault, and assessing of the mood, behavior, and actions of the patient.

A SER representing a long-term care and assisted living facility described their training program as "pretty strong" and said that it focused on crisis intervention and dealing with challenging behaviors. That SER said that newer employees received a great benefit from the initial training but that veteran staff would need refresher training that motivated them, rather than what the SER described as an annual "rubber stamp" by managers and administrators.

Many SERs mentioned the importance of de-escalation training. Some SER said that implementing such training had a major positive impact in reducing the number of WPV incidents at their facilities. One SER said that implementing training caused a

"statistically significant" reduction in incidents and allowed for less use of physical restraints and medication. A different SER described the approach to training within their community healthcare system, and said that it includes de-escalation training, but they wished it were more in-depth.

In addition to de-escalation training, one SER mentioned using Crisis Prevention Institute (CPI) training to train employees in physical skills for safely managing a situation. Another SER mentioned using the training provider Care Academy for training. One SER representing a social service provider said that they have a mental health nurse who conducts critical incident training for staff and volunteers. One SER mentioned that all staff in their facility receive psychological and physical management of behavior training.

Another SER told the Panel that, for incidents that occur at bedsides (e.g., kicking, scratching), their staff receive behavioral training and learn specific approaches for prevention. Once staff and the facility are aware a resident has displayed a propensity for aggressive behavior, these behaviors are evaluated, a care plan is developed to address the issues, and training is provided to protect the staff. This SER said that, to a certain extent, healthcare professionals know these incidents are a part of care, and training helps them to remain on guard and gives them expertise in handling aggressive behaviors. Another SER noted that having worked in an ER, it is not uncommon for patients to spit, kick, push or take a swing at clinicians—and that training is needed for these staff that emphasizes that none of this is acceptable.

SERs discussed various training durations, frequencies, and methods, as well as the use of online platforms and in-house training methods. A few SERs mentioned the importance of frequent training, saying that people "learn by doing" and that skills need to be reinforced, so that when staff need to use those skills, they remember what they learned. One SER said that they found that generic trainings are ignored or "glossed over" by staff and that more interactive and personalized situational trainings have a greater impact. Similarly, another SER felt that employers who had been with their facility longer tended to get less out of refresher training.

In terms of frequency, one SER said that they hold monthly training webinars for staff. One SER representing a social service organization told the Panel that de-escalation

training is provided to staff every 12 to 18 months. Another SER said that they have annual in-person WPV training that all staff are required to take.

In terms of duration, one SER said that general awareness training took 15 or 10 minutes, training for more patient-facing roles took one hour, and training for workers in high-risk positions took four hours and was more hands-on. One SER representing a social service provider said that they use computer, video, and hands-on training and that their WPV prevention training is part of five days of training staff receive upon being hired. One SER said that employees who work with dementia patients receive 12 hours of training and that all staff go through about two hours of de-escalation training per year.

One SER reported that they use internal trainers because outside vendors were found to be too costly and that in-house trainers allowed for added flexibility, which they found helpful in training workers who work different shifts. Another SER who reported using internal staff as trainers told the Panel that they use CPI curriculum to train internal staff to serve as trainers and that the curriculum requires re-certification every three years and maintenance of that certification requirement for trainers. This SER also said that this approach offers flexibility for offering training to staff working multiple shifts, and that they found it to be more cost-effective than using a trainer from CPI.

One SER told the Panel about an optional combative patient drill they were holding. This SER said that the drill was available continuously every half hour for all shifts, took 30 minutes, and involved six people conducting the drill plus an actor and two or three staff taking the training. This SER also said that they are currently training a Behavioral Emergency Response Team, including psychiatrists and physicians.

Some SERs emphasized the distinction between initial training and additional or supplemental training. One SER said that computer-based training on WPV is provided at the time of onboarding but that it takes place alongside a lot of other onboarding materials in the span of one day. The SER continued saying that when new hires are placed in specific departments, additional more-specific computer-based training is provided annually. This SER noted that the training in the electronic format can seem a bit more like “checking a box,” but said their system does have modules on WPV that they have found to be very helpful. The SER noted that the risk of using computer-based

training was having a trainee who may just click through the screens to satisfy the requirement.

Another SER representing a large hospital system described their program of training, consistent with Joint Commission accreditation, as being based upon their program assessment. This system's establishments determine the level of training based upon the roles and responsibilities of the employee, as well as the setting. This SER advocated for this approach, over OSHA's more prescriptive approach of tiered levels training, adding that initial training was a beneficial and necessary component, but that subsequent training should be more focused on the value of the training and should not be, for example, eight hours long. This SER told the Panel that an eight-hour training may not as beneficial for an individual as a more targeted one-hour training on more beneficial topics. This SER said that it would give employers an opportunity to maintain the ability to truly define risks and then provide the level of training necessary for the relevant individuals.

Another SER told the Panel that they had just selected a new training vendor and outlined the training approach. They said that the training provides five different levels based upon risk and are assigned to staff relative to the risk alignment. The SER said that the first level of training is computer-based (informational knowledge) and takes one hour, the second level is staff empowerment to manage stress and overreaction, the third level is non-verbal acuity and interview intervention techniques, the fourth level is verbal de-escalation, and the fifth level is protection from use of force. This SER said that, so far, they have good feedback and outcomes using this training. They also reported performing several exercises or reviews each year based on more common, high-prevalence incidents as well as more uncommon lower-prevalence incidents.

One SER representing a care provider where clients live in residential houses and only a few employees are on site at any time told the Panel that violence in those settings is rare, but that all their employees undergo annual WPV training that is required by their State Department of Human Services. This SER said that refresher sessions are incorporated into staff meetings. This SER also said that they do virtual town hall meetings that have increased staff engagement.

Many SERs raised concerns about the costs of an OSHA training provision, even though they already provided at least some WPV training at their facilities. For example, a SER who directs a transitional housing and vocational rehabilitation program described a training program at their organization which the SER said is guided by CARF. Although their facility currently schedules monthly and annual training, the SER expressed concerns about budgeting for what they perceived as a larger program under OSHA's draft regulatory framework. Another SER representing home healthcare settings said that home healthcare is often operating at a loss. They do their best with training, but the SER said that an additional mandatory training burden from an OSHA standard would be tough to comply with. This SER said that it is unrealistic to bring in 300 certified nursing assistants (CNAs) for training with no reimbursement or government subsidy to cover the time spent in training. This SER expected that the training requirements of OSHA's standard could result in small organizations getting "eaten up" or absorbed by larger organizations because this SER's perspective was that only the larger organizations could afford to comply with an OSHA standard.

A SER representing a large healthcare system indicated that it was impractical to assume that an employer would have a list of who on any given shift has been trained and who has not. The approach that this healthcare uses is to have a two- or three-hour training on de-escalation and then spend a few minutes in weekly or monthly meetings—this healthcare system wants these concepts to be frequently revisited.

One SER mentioned the challenges of training, saying that in their facility, they found it difficult to maintain certified trainers because turnover is high in the industry. Some SERs also acknowledged the high turnover rate in some industries, and some expressed concern that extensive training time can be devoted to training new employees, only to have them leave shortly thereafter. They also found it difficult to dedicate time for staff to be trained, and that these factors make it difficult to prioritize training. Yet another SER said they have a high proportion of part-time employees, which means they are training more people.

Some other SERs expressed concerns about the training of contract travel nurses and the cost of investing in short-term staff training.

Effectiveness of WPV Prevention Programs

SERs who spoke on the issue said they thought that their programs to address WPV were effective, and some SERs shared examples of administrative controls they found to be effective. A SER said that training reduced incidents in their facility and reduced the use of restraints on patients. A SER who represented an elder care provider said that dementia communication training was especially useful. Another SER shared that they had incentivized reporting to help them better address incidents. This SER said that with more staff reporting, reported incidents had gone up but the severity of incidents had gone down. Another SER said that their WPV prevention program helped employees feel safe and helped decrease turnover.

A few SERs expressed concern that an OSHA standard would include requirements that had not been shown to be effective at reducing WPV. SERs encouraged OSHA to be cognizant of data on abatement effectiveness and to allow and encourage innovative approaches to addressing WPV.

Multi-Employer Worksites

Some SERs discussed their existing protocols and practices for multi-employer worksites, in the context of OSHA's draft regulatory framework.

A SER who directs safety and emergency management for a hospital system identified multi-employer safety communication and coordination as keys to an effective violence mitigation program. The SER explained that, in that hospital system's reporting protocol, the identities of directly employed associates are captured in recording WPV events; however, non-employees are not included for purposes of incident logging and investigation.

A SER representing a small transitional housing and vocational services operation commented on the challenges of coordinating hazard communication and training among

multiple partners and expressed concern about the affordability of hosting training for all the medical partners that serve in their community.

Another SER shared that they have a lot of vendors and contractors at their facility and thought that coordination between multiple groups would be difficult. This SER reported that contractors are more heavily used in their emergency department and dialysis center. This SER said that they currently do not do much to coordinate with non-employees with respect to WPV and said that they did not think that non-employees have access to their WPV reporting platform. This SER said that such coordination would require establishing an entirely new system for them.

Employee Participation

Some SERs discussed the importance of employee involvement in safety initiatives, emphasizing the value of annual employee engagement surveys and safety coaches in promoting a safe working environment.

One SER told the Panel that their organization has established a WPV committee with diverse participation that includes both leadership and staff. This SER acknowledge that this committee takes a lot of time and resources. At their facility, they have a safety manager, and WPV takes up about 25 percent of that employee's time. The SER also said security personnel participate on the WPV committee.

Another SER mentioned that they use town hall meetings and employee surveys to help prioritize employee safety issues that can be raised to and addressed at the corporate level.

Costs and Profitability

SERs raised concerns about the cost of implementing additional requirements, beyond costs they already incur to comply with other applicable WPV requirements or guidelines (e.g., as part of Joint Commission accreditation), hiring additional staff, and potential liabilities associated with regulatory compliance. Some SERs told the Panel that OSHA's

unit cost estimates for training, engineering, administrative controls, or recordkeeping were too low, either because OSHA underestimated the amount of time needed or because specific provisions would be more expensive to implement in current (2022/2023) dollars. Many SERs said that they would incur costs related to initial program review, familiarization with the rule, and training if a rule is promulgated as described in the regulatory framework. Some SERs also said that OSHA had underestimated the volume and unit costs of PPE that would be required. For example, some SERs reported that they routinely replaced PPE much more quickly than OSHA estimated.

Some SERs representing smaller entities and entities that are not part of a larger health system, particularly those in social assistance settings, said that OSHA's WPV standard, if promulgated, could impact their ability to continue to provide services at current levels. Some smaller and independent SERs thought that some draft requirements could result in costs that would hinder services for patient care.

Some SERs suggested that OSHA consider providing broader latitude for compliance or that OSHA or the government in general should offer federal funding or resources to help employers implement the potential requirements.

One SER said that OSHA's compliance cost estimates for the assisted living sector in the draft standard seemed low. They thought such costs should be more reflective of OSHA's estimated costs for nursing homes, which they thought would be a more appropriate comparison. A SER who directs safety and emergency management for a hospital system questioned the unit costs in the PIRFA in general, particularly the per-bed costs reported in OSHA's economic analysis.

That same SER, as well as other SERs, expressed concerns that complying with OSHA's rule would necessitate hiring more staff. That SER described a scenario where "multiple full-time employees" would need to be hired to conduct the hazard assessment and any follow-up investigations. Another SER estimated the provider it represented would need to hire nine to eleven more people (two or three per shift) in order to comply with the requirements in the draft regulatory framework. This SER also anticipated costs related to structural modifications. Another SER said they anticipated significant costs associated

with hiring security personnel as a result of an OSHA standard. Yet another SER estimated that it would take 300 hours a year to do a hazard assessment.

One SER representing a vocational rehabilitation services organization stated that adding full-time staff to manage training and additional duties for the new potential rule—at a cost of $50,000 to $60,000 annually—would be a problem. The SER also noted that adding staff to manage administrative and policy details means sacrificing their mission for providing care. Still, that SER acknowledged the merits of a WPV program.

As also discussed in the training section, some SERs thought the annual mandatory training would be very costly. For example, one SER said they preferred a two-year review and certification for training, instead of an annual requirement, because this approach would be less costly.

A SER in the risk and legal division of a hospital stated that their hospital would not close as a result of compliance if OSHA did promulgate a standard, but that that the rule nonetheless would have a large impact on costs, costing them millions of dollars. A SER representing a children's hospital stated that the costs of an OSHA standard likely would not be a prohibitive factor for them to deliver key care services, however, this SER also advocated for stricter attention to a cost-benefit ratio in setting the standard.

Some SERs raised concerns about caps on reimbursements imposed by Medicare, Medicaid, state laws, or other means. A SER representing a home-based behavioral health and recovery service said that their program has caps on the amount that could be billed for government reimbursement, and they would need to fund-raise to achieve compliance with a WPV standard. That SER wondered if the reimbursed expenses for compliance could be counted as overhead for tax purposes.

Another SER representing primarily the home healthcare industry noted that for high-crime area visits, visits involving corrections officers, or bringing detained persons in for a visit, they have retired police officers escort staff. But the minute they walk out the door with a security guard, they have spent more than they are getting reimbursed for. This SER said the same of training and of personal panic alarm devices; they expressed that they could provide the training or provide the devices, but there would be no

reimbursement for that. They said that reimbursement gets cut every year, but the industry trend is toward moving patients out of hospitals and into the home healthcare. This SER stated that there needs to be adequate funding for these services, but did not think that this was going to be happening.

Miscellaneous Comments

Some SERs were concerned about whether this potential rule would cover volunteers. Some SERs in social service sectors and emergency responders said that they rely heavily on volunteers and expressed that it was unclear how a potential rule would impact those arrangements.

Concerns were expressed regarding the implementation timeframe, with some SERs saying that six months to implement the rule was potentially too short. One SER estimated it would likely take their facility up to a year to implement all the requirements in the draft regulatory framework and preferred more of a staged implementation.

WPV SBAR Panel Findings and Recommendations

Introduction

The findings and recommendations presented in this report address issues and concerns raised by participating SERs and reflect the Panel's recommendations with respect to those issues and concerns.

The Panel's findings and recommendations are also preliminary, based on information available at the time this report was drafted. OSHA will continue to conduct relevant analyses and may obtain additional information relevant to the rule development process. Any options the Panel identifies for reducing the rule's regulatory impact on small entities may require further analysis and/or data collection to ensure that the options would be consistent with the Occupational Safety and Health Act of 1970, 29 U.S.C. 651 et. seq. (OSH Act) (the statute authorizing a proposed rule), and adequately protective of workers.

The Panel's recommendations are consistent with the principles that OSHA must make a threshold showing of significant risk of material impairment of safety or health before it can promulgate a safety or health standard. It is only after OSHA makes a general finding of significant risk that the analysis turns to whether the requirements of the standard are reasonably related to the standard's purpose and the rule is appropriately tailored. Further, the Regulatory Flexibility Act requires OSHA to consider significant regulatory alternatives that achieve its statutory objectives while minimizing any significant economic impact on small entities.

Need for a Rule and Alternatives, Risk, and Scope

Finding: *Need for a Rule.* Although many SERs acknowledged that workplace violence in the healthcare and social assistance industries is a problem, some SERs questioned the need for a rule based on their belief that existing regulations, guidelines, accreditations and/or certifications already require them to implement a WVPP or other measures to protect workers from WPV. Many SERs reported having some form of accreditation or certification that requires WPV preventative measures, although some SERs acknowledged those do not include certain elements that OSHA contemplates including in an OSHA WPV standard, such as specifications for controls, violent incident investigation, or recordkeeping. SERs regulated by CMS conditions of

participation (e.g., via the Joint Commission) pointed out that they are required to comply with Joint Commission accreditation standards for WPV prevention. For example, many SERs indicated they already track WPV incidents and already have performance targets for preventing workplace violence. SERs who indicated they are already required to implement WPV protections under other requirements also generally indicated that they are currently in compliance with such licensing, accreditation, or other applicable guidelines.

Many SERs expressed concerns about additional regulation, such as that an OSHA WPV rule would not further reduce workplace violence, could create conflicts with existing requirements, could increase the complexity of WPV prevention control plans without a corresponding safety benefit, could necessitate additional staff due to increased recordkeeping and reporting requirements, or could potentially lead to negative patient outcomes. (With respect to negative outcomes, for example, some SERs suggested that increasing the incidence of flagging patients' electronic health records for aggressive behavior could negatively affect their level or type of care in the future, or that the likelihood of negative behavior could be increased by making the physical environment less inviting.) Some SERs also raised concerns regarding limited resources they have available for control of workplace violence.

Because some SERs believe they are already taking adequate measures to comply with existing WPV accreditation, certification, or other requirements, these SERs stated that compliance with a new OSHA rule would result in few or minimal substantive risk-reducing changes in behavior. Some SERs raised concerns that, notwithstanding the overlapping regulations, they anticipated that they would incur significant costs under a new OSHA rule because they would need to familiarize themselves with the requirements of the new standard and review their WPV prevention programs to ensure compliance with OSHA requirements.

Recommendation: The Panel recommends that OSHA review existing regulations, guidance, and accreditation standards on WPV prevention in determining the need for a rule (e.g., CMS guidance and conditions of participation for Medicare and Medicaid and Joint Commission accreditation standards), avoid duplication unless necessary to mitigate risks associated with workplace violence, and ensure any OSHA requirements do not conflict with other governing bodies or standards-setting organizations.

Finding: *One-Size-Fits-All Approach.* SERs nearly universally expressed concerns that a potential WPV rule would attempt a one-size-fits-all approach that would be difficult for the regulated

entities to comply with. SERs repeatedly told the Panel that the difference between types of entities should be reflected in the requirements included in a proposed rule and that the agency should provide as much flexibility as possible. SERs thought this flexibility was necessary to allow them to address the hazard of WPV in their facility in a way that is most effective for their particular setting while being sensitive to the needs of the population they serve. SERs said that it was important for any potential rule to not be too prescriptive since it might result in requirements to implement approaches that are ultimately found to be ineffective at addressing WPV while stifling employers' ability to try innovative approaches that might be more effective. While SERs overwhelmingly wanted flexibility, some SERs also reminded the Panel that this kind of approach can sometimes make it difficult for small entities to determine exactly what they need to do to comply with an OSHA standard.

Recommendation: The Panel recommends that OSHA's proposed standard be flexible and allow employers to tailor their approaches to complying with the requirements of the rule to the size and complexity of their facility, setting, or industry while offering specificity where possible to alleviate confusion. The Panel also recommends that OSHA consider, to the extent practicable, incorporating elements that are "performance oriented" such that certain requirements are expressed in terms of outcomes, in order to allow sufficient flexibility for employers to pursue alternative innovative approaches.

The Panel also recommends that, should a rule be proposed, OSHA include task- or setting-specific guidance within the preamble of the proposed rule, as well as develop task- or setting-specific education/outreach materials as part of compliance assistance for employers if OSHA finalizes the rule.

Finding: *Risk and Scope.* Some SERs were concerned that significant occupational exposures may not be present in certain industries included in the draft regulatory framework. Some SERs, particularly those representing entities in the social assistance sector, such as supportive housing services and outpatient addiction treatment services, reported that violent incidents were uncommon in their settings. These SERs said that their settings were often different from other healthcare facilities in the level of risk they faced and some of these SERs felt that the level of risk present in their facilities did not warrant coverage under an OSHA WPV safety standard.

Recommendation: The Panel recommends that OSHA evaluate available risk data for each healthcare and social assistance facility/setting and tailor the scope in such a way that eliminates lower hazard, lower risk facilities/settings from the scope of the standard.

Finding: *Scope – Covering Healthcare and Social Assistance.* In addition to the concerns about whether the level of risk in social assistance service settings warrants their inclusion in a WPV standard, SERs representing these settings told the Panel that the requirements necessary to mitigate WPV hazards in healthcare were excessive or not appropriate when applied to their settings. For example, SERs representing supportive housing indicated that access control requirements would not work in such settings, other SERs expressed confusion on how OSHA would expect a food bank to follow the same regulation as a healthcare establishment, and another SER representing a disaster response agency said that OSHA's draft requirements for controls do not fit with the disaster response model as there is no set work site and sites are based on where a disaster occurs. While OSHA intended the regulatory framework to represent a program standard that was scalable to the size and complexity of covered employers, SERs still felt that, by trying to cover so many different industries and types of settings, the regulatory framework introduced unnecessary and unworkable requirements on some settings.

Recommendation: The Panel recommends that OSHA consider the unique conditions of each affected sector and better tailor the requirements in the proposed standard to those conditions. In doing so, the Panel further recommends that OSHA evaluate different ways to structure the regulatory text, for example, by delineating the requirements for healthcare versus the requirements for certain types of social assistance.

Finding: *Correctional Facilities.* SERs who provided healthcare services in correctional settings told the Panel that they did not think an OSHA standard addressing WPV in correctional healthcare settings was necessary. These SERs said that the healthcare settings in correctional facilities are already highly controlled settings in which patient and personnel access and movement are closely controlled, and that measures to mitigate and respond to violent incidents are already fully implemented. OSHA had not included healthcare settings in correctional facilities as part of the main scope of the draft regulatory framework but had considered whether to include these settings in a regulatory option.

Recommendation: The Panel recommends that OSHA not expand the scope to include healthcare settings in correctional facilities unless the agency can identify protections tailored appropriately to the unique nature of those settings.

Definitions

Finding: *High-Risk Service Area Definition.* Many SERs objected to OSHA's draft definition for "High-Risk Service Area," which defined service areas with one WPV incident every three years as "high-risk" for the purposes of the standard's requirements. Many SERs said that under this definition every part of their facility would be considered a high-risk service area. Many SERs questioned the practical utility of the draft definition for high-risk service areas that could require heighted protective measures for the majority of the facility. Some SERs advocated for a "performance-based" or more flexible approach to the identification of high-risk service areas than contemplated by OSHA's draft definition. For example, some SERs suggested an approach that would involve comparing the incident history, frequency of incidents, or other risk or data metrics within a facility, organization, or sector of the healthcare industry, in order to evaluate relative risk within the facility, organization, or sector.

Recommendation: The Panel recommends that OSHA replace the metric used to determine whether an area is a high-risk service area with one that reflects further research about what constitutes heightened risk of workplace violence in covered industries. The Panel recommends that OSHA consider the SERs' various recommendations with respect to defining the term in evaluating what definition to adopt.

Finding: *WPV Incident Definition.* Many SERs expressed concern that OSHA's definition of WPV incident seemed too broad. SERs indicated that different sectors or entities may use different definitions for WPV incident that can range from verbal altercations and/or threats to physical assault causing injury, with a considerable variety of WPV incidents falling in between. SERs also noted that, for some workplaces, violent verbal threats may be commonplace or daily occurrences, depending on the nature of the patients or clients. Other SERs told the Panel that verbal threats, harassment, or abuse have significant negative effects on employees, are considered violent incidents that they want staff in their facilities to report, and that these should be considered WPV incidents under an OSHA standard. Many SERs raised concerns that defining

WPV incident to include verbal threats, when coupled with OSHA's draft definition of high-risk service area, would result in every workplace area being construed as "high-risk." Some SERs requested that OSHA clarify the meaning of a WPV incident based on this feedback.

Recommendation: The Panel recommends that OSHA reconsider the definition of WPV incident, and particularly whether verbal threats should be considered WPV incidents, based on information and feedback from SERs about what they consider to be WPV incidents in different sectors or settings. The Panel recommends that OSHA adopt a definition that, when applied in conjunction with the rest of a WPV standard, results in limits to the standard's applicability that are commensurate with the risk to workers.

Elements of Draft Regulatory Framework

Finding: *Engineering Controls.* Many SERs were concerned with OSHA's draft regulatory framework for engineering controls. SERs interpreted OSHA's framework to require numerous engineering controls that SERs thought would be difficult and costly to implement. Some SERs told the Panel that some engineering controls mentioned in the regulatory framework could not be used (e.g., cameras are not allowed in many areas of healthcare facilities for privacy reasons) or would be counter to the standard of care in their facility (e.g., furniture that could not be rearranged in hospice settings, or barriers in memory care areas that might distress patients). SERs representing residential care settings told the Panel that their facilities are intended to be a comfortable, home-like setting and that introducing many of the engineering controls mentioned in the regulatory framework would negatively affect that feeling in their facilities. Some SERs objected to some panic buttons or alarms, saying they are difficult to maintain and may give employees a false sense of security.

Recommendation: The Panel recommends that OSHA revise the regulatory framework to clarify which engineering controls are appropriate for which types of settings, while maintaining flexibility for employers. The Panel also recommends that OSHA clarify that engineering controls that are counter to the standard of care would not be required by the WPV standard.

Finding: *Previously Unreported Incident Review.* Some SERs expressed concerns about OSHA's draft requirement that, in order to better inform initial and annual hazard assessments, allowed employee reporting of WPV incidents that may have occurred within the prior three years and

had not otherwise been reported. Some SERs said that after-the-occurrence reporting would not be particularly useful because major incidents (e.g., those resulting in injury) were always recorded and that minor, previously-unreported incidents were unlikely to be recalled with enough specificity to conduct a meaningful hazard assessment long after the incident occurred.

Recommendation: The Panel recommends OSHA reconsider the requirement to solicit unreported WPV incidents from the previous three years as part of the hazard assessment and consider options for reducing the number of years of prior workplace violence incidents that may be reported or eliminating the requirement.

Finding: *Training.* The majority of SERs who commented on this subject recognized the value and effectiveness of training in mitigating the incidence of workplace violence and recognized training as a key component of a WPV program. Many SERs said that the most effective training programs are flexible and not one-size-fits-all. Several SERs noted that a hybrid approach that includes written materials, video instruction, and interactive live demonstration can be particularly effective, and many reported that de-escalation training is extremely useful in reducing WPV incidents. Some SERs also told the Panel that the skills necessary to defuse or respond to a WPV incident are most effective when they are practiced or reviewed regularly.

A number of SERs saw the utility of a baseline level of training (anywhere from an hour or so during new employee orientation to as many as eight or 24 hours, depending on exposure to risk) for all employees. Many SERs reported providing at least an awareness level of workplace violence training to all employees at their facility. However, many SERs objected to requiring high levels of training for all staff exposed to workplace violence. SERs expressed concern because OSHA's draft standard contemplated higher levels of training to be tied to the designation of a high-risk service area, which SERs thought would encompass their entire facility under OSHA's draft definition. A number of SERs also expressed concern that it could be costly and wasteful to invest substantial time or money training new employees in positions that experience high turnover.

Recommendation: The Panel recommends that OSHA research and identify effective WPV training programs in healthcare and social assistance and incorporate the elements of those programs into the proposed standard or agency guidance products. The Panel further recommends that OSHA consider training requirements that permit employers flexibility consistent with safety, particularly for training requirements beyond any basic initial training, and that any

requirements for additional training be scalable with respect to the risks employers need to address.

Finding: *Recordkeeping.* Most SERs who weighed in on the topic objected to OSHA requiring employers to document workplace violence incidents, beyond complying with OSHA's existing requirements for recordkeeping that apply to all industries. Although most SERs reported that they already document incidents in their facility, they generally thought additional documentation requirements in an OSHA WPV standard would be costly and duplicative. Most SERs agreed that it was important to track incidents to keep aware of trends and problems that may arise. Some of the objection to the recordkeeping requirements may have stemmed from what the SERs saw as an overly broad definition of what was a WPV incident that would need to be recorded or a concern that OSHA would require a specific form or template for recording incidents.

Recommendation: Along with the recommendation on the definition of a WPV incident discussed above, the Panel recommends that OSHA clarify the recordkeeping requirement to make it clear that, while certain information should be recorded about an incident, there would not necessarily be a requirement for a separate form or format that employers would be required to use, particularly if necessary information was being captured elsewhere in a different format. The Panel recommends that OSHA clarify its intention that, in many cases, employers would be able to use, or at least modify as applicable, their existing recordkeeping systems and program.

Finding: *Cost Estimates.* Some SERs told the Panel that OSHA's unit cost estimates for training, engineering, administrative controls, or recordkeeping were too low, either because OSHA underestimated the amount of time needed or because specific provisions would be more expensive to implement in current (2022/2023) dollars. Some SERs also said that OSHA had underestimated the volume and unit costs of PPE that would be required. Many SERs said that they would incur costs related to initial program review, familiarization with the rule, and training if a rule is promulgated as described in the regulatory framework. For example, some SERs reported that they routinely replace PPE much more quickly than OSHA estimated, whereas other SERs reported that the engineering designs recommended in the preliminary economic analysis failed to account for cultural and therapeutic needs within care settings.

Some SERs representing smaller entities and entities that are not part of a larger health system, particularly those in social assistance settings, said that OSHA's WPV standard, if promulgated,

could impact their ability to continue to provide services at current levels. Some smaller and independent SERs thought that some draft requirements could result in costs that would hinder services for patient care.

Recommendation: The Panel recommends that OSHA conduct additional research and review the accuracy of its unit cost estimates, estimated use frequencies, and current price levels (making inflation adjustments where necessary) based on additional information, including information provided by the SERs.

The Panel also recommends that OSHA carefully examine the additional costs associated with administrative activities, such as the costs associated with an employer familiarizing itself with a new OSHA standard and reviewing its programs to assess compliance, in evaluating regulatory costs and in determining whether the rule is necessary and economically feasible.

Appendix A: List of SBAR Panel Members and Staff Representatives

Small Business Advocacy Review Panel Members and Staff Representatives for the Potential Standard on Prevention of Workplace Violence in Healthcare and Social Assistance

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Ryan Tremain	OSHA
Bob Blicksilver	OSHA
David O'Connor	OSHA
Chuck McCormick	OSHA
Bryan Lincoln	OSHA
Aalok Oza	OSHA
Rachel Carse	OSHA
Carl Lundgren	OSHA
Joo-Hyung (Grace) Shin	OSHA
Britni Wilcher	OSHA
William Baughman	OSHA
Annette Iannucci	OSHA
Rachel Michel	OSHA
Varun Patel	OSHA

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Richard Ewell, Department of Labor, Office of the Solicitor (DOL SOL)

Ashley Briefel DOL SOL
LaNita McWilliams DOL SOL
Leigh Anne Schriever DOL SOL
Cathy Seidelman DOL SOL

Erin Fitzgerald, Department of Labor, Office of the Assistant Secretary for Policy

Charles Maresca, Office of Advocacy, Small Business Administration

Appendix B: List of SBREFA Teleconference Participants

SBREFA Convened on the Draft Prevention of Workplace Violence in Healthcare and Social Assistance Standard
List of Small Entity Representatives (SERs)

SER Name	Organization Represented
Tina Charest	Androscoggin Home Healthcare and Hospice
Maggie Sumioka	Asana Recovery
Scott Cormier	Ascension Healthcare
Luis Collado	Baptist Health South Florida
Scott Normandin	Baptist Health System
Mary Jackson	Baptist Retirement Community
Gerald Hamilton	Beehive Homes of Volcano Cliffs
Randy Arnett	Big Sandy Healthcare
Ryan Pirtle	BJC Healthcare
Kurt Barwis	Bristol Hospital
Pam Hayle	Cassia
Amanda Scott	Children's Hospital, Philadelphia
Cary McKee	Communities of Recovery Experience - USA
Michael Bomberger	Community Healthcare System - NE Kansas
Doug Jones	Confluence Health
Dave Denniston	Cortlandville Fire Department
Peggy Connorton	Covenant Health
Steven Kroll	Delmar-Bethlehem EMS
Anne and Bo Weaver	Fairbanks Community Food Bank
Mike Hamel	Hoag Memorial Hospital Presbyterian
Heather Keafer	JEVS Human Services
Debra Abromaitis	John Dempsey Hospital/UCONN Health
Daniel Selby	Knox Community Hospital
Kristi Safranek	Lawrence County Memorial Hospital
John D'Eramo	MCCA, Inc.
Cathryn Schlesinger	Memorial Hermann Southwest
Denis Hyams	Memorial Hermann Southwest
Eric Clay	Memorial Hermann Southwest
Michael Hatten	Missouri Slope
Jared Shapiro	Montefiore Health System
Phillip Gregg	Ohio Health
Bobbi Jo Hurst	Orthopedic Associates of Lancaster

SER NAME (Cont'd)	ORGANIZATION REPRESENTED (Cont'd)
Michael Jalazo	People Empowering and Restoring Communities
Mary Myers	Potomac Home Healthcare
Pam Clingerman	Prisma Health–Upstate
Dr. C. Ryan Keay	Providence Regional Medical Center - Everett
Lisa Landry	Redington-Fairview General Hospital
Maria Sullivan	Southeastern Council on Alcoholism & Drug Dependence, Inc
Marcy McNeal	Sunrise Hill Care Center
Steve Havas	The American Red Cross
Nancy Holcomb	The Barry Robinson Center
Jeremy Klemanski	The Gateway Foundation
Ann Reifenberger	The Legacy at St. Josephs
Laura Farrell	Trinity Community at Beaver Creek
Marcy Kuhnhenn	Trinity Health First Response
Aaron Stapleton	Trinity In-Home Care
Amy Woznyk	Yale New Haven Health
Mark Sevilla	Yale New Haven Health

Appendix C: Written Comments from SBREFA Teleconference Participants

Linda Bergonzi-King, Yale New Haven Health System

Bobbi Jo Hurst, Orthopedic Associates of Lancaster

Jared Shapiro, Montefiore Health System

Michael Bomberger, Community Healthcare System - NE Kansas
(letter and attachment)

Gerald Hamilton, Beehive Homes of Volcano Cliffs

Mary Myers, Potomac Home Healthcare

Linda Bergonzi-King, Yale New Haven Health System

Workplace Violence Standards

(As of April 3, 2023)

The Joint Commission (TJC) ***(February 2023 Hospital Accreditation Program)***	**Occupational Safety and Health Administration (OSHA)** ***Proposed Standard***	**Connecticut Department of Public Health (DPH)** ***Public Act No. 11-175, July 2011*** ***AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTHCARE SETTINGS.***
Standard LD.03.01.01: Leaders create and maintain a culture of safety and quality throughout the hospital. EP 9: The hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team.	**(1) A workplace violence prevention program (WVPP)** - employers would be required to develop (with the involvement of employees) and implement a written WVPP.	Section 1b. Each healthcare employer shall establish and convene an ongoing workplace safety committee to address issues related to the health and safety of healthcare employees and shall develop and implement a written workplace violence prevention and response plan.
Standard EC.02.01.01: The hospital manages safety and security risks. EP 17: The hospital conducts an annual worksite analysis related to its workplace violence prevention program.	**(2) Hazard assessments** - Employers would be required to perform regular hazard assessments based on their own injury records and identify and mitigate hazards.	Section 1c. Each healthcare employer shall undertake a risk assessment of the factors that put any healthcare employee at risk for being a victim of workplace violence.
EP 17 (continued) The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis.	**(3) Implementation of Control Measures** - Employers would be required to implement controls to mitigate the hazards found during the hazard assessment.	

Linda Bergonzi-King, Yale New Haven Health System
Workplace Violence Standards
(As of April 3, 2023)

The Joint Commission (TJC) ***(February 2023 Hospital Accreditation Program)***	**Occupational Safety and Health Administration (OSHA)** ***Proposed Standard***	**Connecticut Department of Public Health (DPH)** ***Public Act No. 11-175, July 2011 AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTHCARE SETTINGS.***
Standard HR.01.05.03: Staff participate in ongoing education and training. EP 29: As part of its workplace violence prevention program, the hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leadership, staff, and licensed practitioners.	**(4) Training** - OSHA is considering specific training requirements for employees and their supervisors. Education and training are key elements of a workplace violence prevention program and help to ensure that all staff members are aware of potential hazards and how to protect themselves and their coworkers through established policies and procedures.	Developing and implementing a workplace violence prevention and response plan, including policies and training programs to prevent and respond to workplace violence.
Standard EC.04.01.01: The hospital collects information to monitor conditions in the environment. EP 1: The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating…	**(5) Incident investigation and maintenance of a workplace violence log** – Employers would need to maintain a specific workplace violence recordkeeping log and perform incident investigation procedures.	Section 2. A healthcare employer shall maintain records which detail incidents of workplace violence and include the specific area or department of the employer's premises where the incident occurred. Each healthcare employer must report to DPH annually the number of intentional workplace violence incidents occurring on the employer's premises during the preceding calendar year and the specific area or department of the employer's premises where such incidents occurred.
YNHHS has an overall system policy: Non-Retaliation and Non-Retribution for Reporting Policy	**(6) Anti-retaliation policy to encourage employee reporting of workplace violence incidents**	

Linda Bergonzi-King, Yale New Haven Health System
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"An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors."	*"Workplace violence incident* means any violent act (including physical assault and threat of physical assault) directed toward persons at work or on duty by patients or their visitors. It may or may not result in injury."	Connecticut DPH defines workplace violence as "any physical assault, threatening behavior or verbal abuse occurring in the work setting. It includes, but is not limited to, beatings, stabbings, suicides, shootings, rapes, near suicides, psychological traumas such as threats, obscene phone calls, intimidating behavior, and harassment of any nature such as following, swearing at or shouting at another employee(s).

Bobbi Jo Hurst, Orthopedic Associates of Lancaster

The Association of Occupational Health Professionals in Healthcare (AOHP) has long been providing education and support for this initiative for several years at conferences, various educational programs and through our position statement. We were excited to participate with The Joint Commission (TJC) as they began implementing the standard when accrediting institutions on behalf of Centers for Medicare & Medicaid Services (CMS). Currently, accrediting bodies, TJC and the Det Norske Veritas Healthcare (DNV) have requirements outlined for CMS credentialed organizations, most of which meet the proposed Occupational Safety and Health Administration (OSHA) standard.

AOHP, which largely represents persons in the healthcare industry, believes all entities should have a Workplace Violence Program (WPV). The program should be tailored to the specific entity type. To prevent two sets of regulations to follow, when an entity is a CMS credentialed organization, following the CMS requirements should exempt them from also abiding by the new OSHA standard. For those organizations that are not CMS credentialed, we believe they should be required to provide a WVP and plan tailored to their specific entity type.

Regarding scope, OSHA has spoken to overall risk levels as well as individuals who hold specific position types. AOHP recognizes there are certain individuals based on their jobs who are more susceptible to workplace violence, however, with that said, there are many variables among each position. A WPV should include an evaluation of the organizations risks as well as individual department and position risks noted by tracking and trending this data. This evaluation will assist in defining the organizations "high risk" area based on an institutions risk assessment and data rather than one defined by OSHA.

The WPV should be written for all organizations and include a workplace hazard assessment. The WPV and hazard assessment shall be reviewed at least annually as violence incidents, technology and education are continuously changing.

Effective safety programs include managerial and non-managerial staff, and this should be the same for the WPV. It provides an opportunity for management to work with staff employees to determine the best actions to be taken to assist in reporting of incidents as well as developing actions to be taken to reduce the risk of violence to staff. The hazard controls that are instituted may not be the same for each entity and shall be specific to the hazards identified in the individual areas. Requiring a specific control for all may not be appropriate, however, it would be helpful for OSHA to provide education on hazard controls that are available and may be considered by individual entities and areas within each entity.

Education is a crucial component for a successful workplace violence program. First educating employees as to what is violence and how to report it is a key element. Each organization shall educate management and staff in regards what constitutes workplace violence whether it is verbal or physical. All employees should receive this education along with how to report a workplace violence incident. Further education for all staff should include de-escalation. Additional education for employees shall be based on the risk assessment and the type of violence they may encounter while at work.

The risk assessment which the education is based on cannot be completed unless there is incident investigation and recordkeeping for all violent incidents. AOHP does not believe the

recordkeeping should mean that another OSHA Log needs to be kept. We do believe that recordkeeping and trending is a priority but should not be another OSHA log. Occupational Health Professionals continue to track and trend many types of incidents that are not serious enough to be on the log and may even be near misses. This information assists us in developing program to protect our employees.

Thank you again for allowing us to provide input into the development of a Workplace Violence Program as we believe protecting the staff we serve as Occupational Health Professionals is a priority. With this we ask that you provide a flexible plan to allow for organizations to follow the credentialing bodies plans as well as develop plans appropriate to their organization.

To: Andrew Levinson, MPH, Director, Directorate of Standards and Guidance, Occupational Safety and Health Administration

From: Jared Shapiro, DrPH(c), PhD(c), MPH, CEM, HEM, FAcEM, CHSP, CHFM, NRP, Associate Vice President, Environmental Health and Safety, Montefiore Health System

Date: March 23, 2023

Re: Docket No. OSHA-2016-0014 – Public Comment on OSHA's Rules Concerning Workplace Violence in Healthcare Settings

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Montefiore Health System is one of New York's premier academic health systems and is a recognized leader in providing exceptional quality and personalized, accountable care to approximately three million people in communities across the Bronx, Westchester, and the Hudson Valley. Montefiore is comprised of ten hospitals, including the Children's Hospital at Montefiore, Burke Rehabilitation Hospital, and more than 200 outpatient ambulatory care sites, home health agency and has an EMS license to provide prehospital care. The advanced clinical and translational research at its medical school, Albert Einstein College of Medicine, directly informs patient care and improves outcomes. From the Montefiore-Einstein Centers of Excellence in cancer, cardiology, and vascular care, its pediatric programs, and its transplantation services, to its preeminent school-based health program, Montefiore is a fully integrated healthcare delivery system providing coordinated, comprehensive care to patients and their families.

Montefiore is not only committed to providing healthcare to New York communities and education to future doctors, researchers, and nurses, it is also committed to the safety and health of its employees and staff. As such, Montefiore maintains and regularly improves a detailed workplace violence prevention program. As Montefiore's Associate Vice President of Environmental Health and Safety, I was a panelist on OSHA's Small Business Advocacy Review Panel (the "Panel") on March 21, 2023, and I shared my thoughts on OSHA's proposed changes to the Workplace Violence Prevention standard. A summary of my thoughts are included herein.

In February 2023, OSHA published a 251-page document, titled "Prevention of Workplace Violence in Healthcare and Social Assistance – Issues Document," which purported to lay out the framework for OSHA's Workplace Violence Prevention standard. Despite its length, the document often does not provide specific guidance for employers like us to ensure they are in compliance; rather, it vaguely describes the rules and regulations, and offers examples which *may* be applied at the discretion of each investigator and OSHA Area Office. Such vague guidance not only creates a regulatory headache for us, it also is nearly impossible for us to comply with as it does not take into account unique characteristics of each hospital, both in terms of the pre-existing layout of the hospital and the volume of people is serves.

Some examples of these ambiguous standards include: (1) the definition of "High-Risk Service Areas;" (2) impractical engineering controls; (3) incident investigation requirements (root cause analysis); (4) flagging or tracking patients; (5) duplication of tracking logs; and (6) duplicative

standards. The proposed Workplace Violence Prevention standard is replete with examples such as these, but I will focus on these six based on their widespread applicability.

1. **The Definition of "High-Risk Service Areas"**

OSHA defines "High Risk Service Areas" as "[a]n area where a workplace violence incident has occurred in the previous three years." (OSHA's Prevention Document, 6). When coupled with OSHA's expansive definition of workplace violence which includes "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site," (Workplace Violence Overview, Occupational Safety and Health Administration Safety and Health Topics, US. Dept of Labor,), this overly broad approach likely encompasses vast majorities of many hospitals. Further, this expansive scope of "High Risk Service Areas" makes it exceedingly difficult for hospitals to comply with abatement methods prescribed by OSHA as hospitals, who are focused on caring for patients, and do not have unlimited resources or staffing.

If this legislation were to move forward, I propose that "High Risk Service Areas" should be determined based on an annual review of workplace violence records and include *only* the areas which have the highest rates of workplace violence. This would allow organizations to focus its resources on *actual* high-risk areas. By maintaining a broad definition of "High Risk Service Area," OSHA is seemingly prioritizing the issuance of citations over employee safety, as the current definition nearly ensures that employers will never be in compliance with the vague and over broad standard.

As I explained during the Panel, as a part of most organization's emergency management and preparedness programs, we conduct an annual Hazard Vulnerability Analysis ("HVA"). A HVA and risk assessment is a systematic approach to identifying hazards or risks that are most likely to have an impact on the hospital. We rank the hazards in order of their impact, and work throughout the year preparing for and responding to these top identified hazards. For example, if our top hazard was a surge of injured patients to our emergency room, we would write policies to respond to this event, train our staff on rapid triage and decision making, ensure the proper medical equipment is available and test the plans through a simulated exercise. As our preparedness increases, the risk becomes reduced and is no longer a top hazard. If we take the same approach for workplace violence, we would be able to focus on the areas or departments that are identified as the highest risk and reduce the risk with preventative measures.

2. **Impractical Engineering Controls**

When an employer receives a citation for a workplace violence violation, OSHA provides a series of recommended abatement measures for the employer to "consider" implementing. While many of the measures may have facial validity, most of them fail to take outside factors into account. OSHA's recommended engineering controls include:

- Access controls to employee-occupied areas;
- Enclosed workstations with shatter-resistant glass;
- Deep service counters or other means to physically separate patients/clients/residents and their visitors from employees;

- Separate or isolation rooms or treatment areas for patients with a history of violence;
- Locking mechanisms for doors;
- Removing access to or securing items that could be used as weapons;
- Furniture affixed to the floor;
- Closed-circuit video monitoring and recording;
- Metal detectors at entrance points (installed or handheld);
- Other means of assuring visibility such as mirrors and improved illumination;
- Personal alarm devices; or
- Other engineering controls.

(OSHA's Prevention Document, 68). Many of these controls, especially if applied pursuant to OSHA's definition of "High Risk Area," would not only be an exorbitant cost to already struggling hospitals and health systems, but also impractical, obstructive, and may create additional or greater burdens for providing clinical care. For example, it would be extremely expensive and obstructive if Montefiore was required to enclose all workstations with shatter-resistant glass in all "High Risk Areas," which, as currently defined, would include a majority of medical units at each hospital. Providing patient care involves creating a patient-to-provider relationship and not a barrier between clinicians and their patients. Additionally, implementing locking mechanisms for doors are impractical and obstructive, and could create a greater hazard where employees may find themselves locked in a room with a violent patient, or where security staff is locked out and unable to provide assistance. Moreover, NFPA 101 (2012) also known as the Life Safety code, which hospitals are required to follow by CMS, prohibits the locking of doors in hospitals with limited exception under the special locking arrangements subsection. Further, removing items which *could* be used as weapons is not feasible, as nearly any object, including pens and pencils, can be used as weapons. Hospitals need supplies to perform their day-to-day responsibilities and to provide effective patient care.

Finally, OSHA's recommendation to place patients who have a history of workplace violence in isolation is not only impractical; it fails to consider the overpopulation hospitals frequently face. Isolation also known as seclusion is *not* allowed in hospitals without a physician's order and a clinical rational. The use of restraint and seclusion is associated with increased risk of injury to both patients and staff who utilize these interventions. Seclusion and restraint also may have deleterious effects on patients, including survivors of sexual trauma and/or physical abuse, and patients with hearing impairments who are unable to communicate without the use of their hands. Physical risks include serious injury or even death, and psychological injuries include re-traumatization for individuals with histories of abuse.

In the State of New York, 14 NYCRR §526.4(b) states, "restraint and seclusion can be used for purposes of managing violent or self-destructive behavior only as safety interventions in emergency situations when necessary to avoid imminent, serious injury to the patient or others, and less restrictive interventions (including any such interventions that have been identified in a patient's behavioral management plan) have been utilized and determined to be ineffective, or in rare instances where the patient's dangerousness is of such immediacy that less restrictive

interventions cannot be safely employed." OSHA's proposed standard would violate New York State law as it would require seclusion as a preventative measure and not only as "interventions in emergency situations when necessary to avoid imminent, serious injury."

Because employers take OSHA's recommended abatement measures seriously, the measures require serious thought and must take into account not only an employer's ability to implement these standards, but also any hazard a measure may create and external the legal ramifications hospitals will face from other governmental agencies.

3. Violent Incident Investigations

OSHA seeks to require a "root-cause" analysis for all workplace violence incidents, which includes threats and "near-misses." This requirement is not only overly burdensome, but also difficult for us to comply with as threats and near-misses are subjective and vary from employee to employee. In addition, the requirement for employees to report all "threats" and "near misses" would congest us with reports, leaving little resources to handle actual threats of violence.

Further, to identify the "root-cause" of each incident, we would need to "document the significant contributing factors of workplace violence incidents and any recommendations received, and corrective measures decided upon and taken." (OSHA's Prevention Document, 88). Montefiore would need to hire a team of investigators who would only interview staff on alleged threats and near-misses. Not only would this consume valuable staff resources and time, it would pull staff away from patient care.

Instead of requiring employers to complete an exercise with little added value, OSHA should only require a "root-cause" analysis when a reportable injury occurs (loss of eye, hospitalization, loss of limb, etc.). A general investigation, as defined by hospital policy should occur in all other workplace violence encounters involving injury. Such requirement would be narrow in scope, more feasible and practical, and would provide the employer with actionable information which may prevent future acts of workplace violence.

4. Flagging or Tracking Patients with A History of Workplace Violence

OSHA's proposed standard would require employers to "flag" patients with a violent history or patients who have the "potential" for violence in a medical file to notify "all relevant staff." (OSHA's Prevention Document, 74). OSHA also may require: "simple stickers of certain colors, shapes, or icons may be placed on patient-assignment boards, patient room doors, above a patient's bed, or on their mobility aids to serve as effective safety cues – particularly for members of the care team who may not have access to patient medical records (e.g., housekeeping, maintenance, dietary staff, etc.)." (OSHA's Prevention Document, 74). These requirements are concerning for a number of reasons.

First, such requirement will inevitably lead to disparate treatment for patients with a history of violence, even if they are not exhibiting any violent tendencies during that specific visit. Such disparate treatment may include, but is not limited to, isolation, reduced visits from nurses, and/or lower quality of healthcare treatment. While employers will do their best to prevent this treatment,

employees are likely to engage in these tendencies out of fear. Further, it should be noted that just because a patient engaged in violent behavior during one visit, does not mean the patient will exhibit similar behavior in the future.

Second, the inclusion of an incident of workplace violence (including threats and near misses) in a patient file is subjective and will not be equally applied. Not only will the inclusion of workplace violence incidents in medical files be varied, the patient medical files may also be discoverable (i.e. during unrelated litigation, for job applications, etc.…). This threatens patient confidentiality.

Third, a coding system does not adequately protect a patient's privacy rights. For example, a "color, shape, or icon" code placed on patient's door would signal to everyone, including the public, that the patient at one time may have engaged in workplace violence (as defined by OSHA), or at the very least has a unique condition. Finally, such program is too permanent and does not take into account the transient nature of healthcare.

While an expansive patient tracking system presents a myriad of issues, there is a reasonable compromise: only tracking incidents of violence which resulted in employee injury. This tracking designation would remain private, and appear only in a patient's confidential medical records. This would allow any employee treating the patient to have knowledge of the previous incident and take any necessary precautions pursuant to the hospital's policies. The marking or designation should be removed after a set period of time if the patient did not have a further incident of violence.

5. Duplicative Tracking Log

OSHA already has a requirement for employers to maintain OSHA 300 and 301 logs which provide all of the information noted in the Violent incident log section of the proposed standard. (OSHA's Prevention Document, 48, 57). An employee's name, the time of the incident, description of the incident, nature of the injuries, whether the employee required medical attention, days away from work, and information about the person completing the log are already existing requirements under the OSHA recordkeeping standard. Duplicative logs create an undue burden for an already overworked healthcare workforce and provide little, if any, additional preventative value. A simpler approach would be to amend the OSHA 300 and 301 logs to add one additional sub-section for injuries stemming from workplace violence, to include "a description of risk factors present at the time of the incident (e.g., whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, in a high crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances)," as this appears to be the only new type of information sought.

6. Duplicative Standard

Hospitals participating in reimbursement programs (including but not limited to Centers for Medicare & Medicaid Services) through the federal government are already required by the to

abide by existing workplace violence standards. Hospitals also must comply with the standards under the joint commission regulations which include:

- Conducting an annual worksite analysis related to its workplace violence prevention program;
- Establishing a process(es) for continually monitoring, internally reporting, and investigating the following Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence; and
- Establishing a process to collect data by monitoring, reporting, and investigating workplace violence incidents allows the hospital and critical access hospital to identify risk factors in the vulnerable areas and implement environmental controls, education, and other mitigation strategies.

(The Joint Commission, *Workplace Violence Prevention Standards*, R^3 Report, Issue 30, June 18, 2021 https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/wpvp-r3_20210618.pdf). As part of its workplace violence prevention program, hospitals provide training, education, and resources (at hire, annually, and whenever changes to the workplace violence prevention program occur) to leadership, staff, and licensed practitioners. Hospitals determine what aspects of training are appropriate for individuals based on their roles and responsibilities.

Hospitals already are required to conduct workplace violence prevention training, education, and provide resources addressing prevention, recognition, response, and reporting of workplace violence, and include, what constitutes workplace violence; education on the roles and responsibilities of leadership, clinical staff, security personnel, and external law enforcement; training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents; and the reporting process for workplace violence incidents.

Hospitals are also already required to have a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team which includes the following:

- Policies and procedures to prevent and respond to workplace violence;
- A process to report incidents in order to analyze incidents and trends;
- A process for follow up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary; and
- Reporting of workplace violence incidents to the governing body.

Imposing additional, duplicative regulations on an already highly regulated industry only serves to apply undue pressure, costs, and burden with little, if any, benefit.

Conclusion

For the reasons stated above, OSHA must consider the impact such proposed guidance will have on employers of all sizes. While much needs to be done to ensure hospital staff are protected from patient violence, a vague and overly burdensome standard will not accomplish that goal, rather it will create more issues and undermine OSHA's main goal: employee safety.

Community HealthCare System
NE Kansas

Centralia | Corning | Frankfort | Holton | Onaga | St. Marys | Westmoreland

April 7, 2023

Bruce E. Lundegren, Assistant Chief Counsel
SBA/Office of Advocacy
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Tel.: 202.205.6144 // Cell: 703.863.8157

Re: OSHA SBAR/SBREFA Panel on "Workplace Violence in Healthcare and Social Assistance"

Dear Mr. Lundegren,

I wish again to thank OSHA and SBA for the opportunity to participate in the early stages of the rulemaking process for this potential standard. I particularly appreciate the difficult work of addressing workplace violence without placing undue burden on either the facility and personal providing the care or the patients themselves. The provision of comprehensive SBREFA materials and courtesies extended to the participants via Zoom meetings and small panel groups were especially helpful.

Community HealthCare System, or CHCS, is a Critical Access Hospital System with more than 485 associates at seven locations providing healthcare to a large service area in rural northeast Kansas. CHCS comprises a hospital including an emergency department, lab, imaging, rehabilitation, and surgery; 6 clinic campuses; 2 nursing homes; plus assisted living and home health care environments. I offer the following recommendations on behalf of CHCS.

<u>Recommendations</u>

- We advocate against duplication, redundancy, and especially conflicts with existing regulations and licensing requirements, noting that time spent necessarily runs the risk of taking time away from patient care.
- We advocate for scalable, flexible, focused programming that finds its foundation in clear definitions (high risk, tracking, trending, training, and reporting).
- We advocate for consequences for perpetrators with an emphasis on the key concept of intentionality.
- We advocate for a consultative vs. a regulatory approach, not unlike OSHA SHARP, which would provide for further root cause analysis and insights into the types of workplace violence and operational steps to address them.

Alongside of the above, we also advocate for development of workplace violence situational awareness and anticipatory critical thinking in educational settings to “inculcate experience” in advance of potential conflicts where possible.

Lastly, Community HealthCare System would advocate that we remember the role excellent customer service plays in mitigating much of this before it begins. An axiom in our business says, “Patients don’t care how much you know until they know how much you care.” It’s true.

As always, please let me know if you have comments or questions or if I can provide additional information.

Best Regards,

Michael J. Bomberger, Director
Business Development and Special Projects
785-336-4060 (cell)

Issue	Page #	My answer
OSHA has selected the sectors listed in the scope because OSHA's experience, BLSOSHA has selected the sectors listed in the scope because OSHA's experience, BLS data, and the best available epidemiological literature consistently demonstrate that these sectors have the highest potential risk for WPV. OSHA welcomes feedback from the SERs on the draft scope of the standard	9	
Is it appropriate to include all employers that are currently identified as within the scope of this draft standard? Why or why not?	9	YES - those areas have potential to experience WPV due to patients feeling out of control, pain, or hopeless.
Should any types of employers or entities currently included in the scope of this draft standard be excluded? If so, please specify the type of employer or entity, and explain why.	9	NO - All areas proposed are impacted by WPV. Excluding any of those areas leaves them open to harm.
Has OSHA overlooked any sectors or service providers that would be included as defined by the scope in the regulatory framework but whose unique workplace violence risk factors have not been accurately or fully recognized in the PIRFA. Or are there sectors or service providers that should be included but are not? If so, please identify them and give the reasons why they would or should be included.	9	YES - Rural Health Clinics are at separate locations and have fewer staff on site. NON-patient care areas experience WPV like billing, HIM, Access Services, and Registration.
Direct patient/client/resident care means job duties that involve the delivery of healthcare services or social assistance services with hands-on or face-to-face contact with patients or clients. Workers who provide direct patient/client/resident care include nurses, physicians, technicians, home care workers visiting client homes, as well as workers providing emergency medical services.	12	
Direct patient/client/resident contact means job duties where workers perform support work that requires them to be in patient/client/resident care areas. Such work includes housekeeping, maintenance, meal delivery, security, and information technology	13	Registration staff, HIM (birth certificate information gathering), billing staff (to answer patient's questions).

Issue	Page #	My answer
Do you agree with OSHA's preliminary approach that addresses both patient/client/resident care employees and patient/client/resident contact employees? Why or why not?	18	NO - **Patients get confused all the time about which staff are in what role.** I have have patients ask the housekeeper questions thinking he/she was their doctor. Anyone that could interact with a patient, visitor, or family member should have training on WPV. Additional training is needed for healthcare workers that work in high risk areas and need training on de-escalation or dementia or situational awareness. Overall, I believe the basics have to be covered by all employees employed at a healthcare facility.
Is there a different distinction OSHA should make between different types of workers? For example, are there additional divisions of workers that would better represent different levels of risk of exposure to potential WPV situations?	18	Proposed names (in my opinon) are too similar. My recommnedation is to change to names to direct patient care staff and non-direct patient care staff. **ALSO** Instead of looking at level of interaction with patients it is important to consider the patient. Is the patient stressed from new diagnosis and overwhelmed with questions? Does the patient feel lonely? Is the patient frustrated and feels they are not being taken seriously or their opinions are being ignored? I also think that availablity allows for opporutunities for violence. Meaning is the area secured or could a patient make there way in and not raise any alarms. When a patient is in our facility they have access to our cafeteria, lobbies, patient registration, billing, HIM, etc. We recently installed badge access to our clinic, lab, and radiology departments.
Is it clear to Small Enity Representative (SERs) how OSHA has presented the contemplated coverage for workers who have direct patient/client/resident contact vs. workers who provide direct patient/client/resident care – as well as the rest of the workers in a covered establishment	18	NO - Names proposed are too similar and will contribute to confusion. Better names would be Direct patient care staff and Non-direct patient care staff.
OSHA welcomes any feedback on the types of employees potentially covered by a WPV Prevention standard. Are there any employees that OSHA has not considered that you think should be included? And conversely, are there any employees OSHA has included that you think should be excluded? Please explain your answer if possible.	18	YES - Rural Health Clinics are at separate locations and have fewer staff on site. NON-patient care areas experience WPV like billing, HIM, Access Services, and Registration.

Issue	Page #	My answer
As an owner or operator of a healthcare or social assistance facility, are your **direct patient/client/resident care (PCCRC)** employees exposed to a higher risk of WPV due to their closer proximity and work with the serviced population?	18	Difficult to conclude when we have low numbers of incidents reported on an annual basis. It is safe to assume that direct patient care staff have more patient interactions and would have increased chances of experiencing violence. But I think that our billing department has patient contact when the patient is angry or upset on a frequent basis.
Are the per-facility estimates of PCCRC employment in Table 4 consistent with your observation for your establishment or agency and with your NAICS industry? If not, please describe how your observed employment patterns differ from those presented in Table 4.	18	There is big gap between small and very small. Our home health consists of 13 members. So they would fall in between the small and very small classification.
OSHA welcomes comment on the employment of PCCRC employees in your facility, including the trends in employee turnover (hiring and separation) that you have observed in your industry. What are external and/or internal factors that can impact PCCRC turnover?	18	We have experienced turnover of about 1/5 of our workforce annually. Small percentage of the employees leave due to being retirement age. Another percentage of employees leave due to marriage, moving closer to family, or better pay. I would say we have lost staff due to burn out because they do not want to deal with the uncertainity of their safety.
Should OSHA include both direct patient/client/resident care AND direct patient/client/resident contact employees in the scope of this potential standard for some or all provisions? Are there any scenarios where it would be appropriate to exclude some workers from some, or all, of the potential standard?	19	It makes sense that both groups get basic training. In small facilities it makes sense that the training for both groups is the same. In small rural facilities we depend on our co-workers to jump in and help if a crisis arises.
If OSHA were to exclude patient/client/resident contact employees from the scope of the standard, would significant risk of harm from WPV remain for those non-covered workers?	19	YES - **Patients get confused all the time about which staff are in what role.** I have have patients ask the housekeeper questions thinking he/she was their doctor. Any staff that could interact with a patient, visitor, or family member should have a basic understanding of workplace violence and how to prevent workplace violence. Additional training is needed for healthcare workers that work in high risk areas and need training on de-escalation or dementia or situational awareness. Overall, I believe the basics have to be covered by all employees **employed at a healthcare facility.**

Issue	Page #	My answer
Are there circumstantial differences between employees whose work responsibilities involve direct patient, client, or resident contact versus those that provide direct patient, client, or resident care, in terms of the amount of time spent in close proximity with patients, clients, or residents? Specifically, OSHA asks about the nature of these interactions, the surroundings in which the interactions take place, or other work differences that make it more or less likely that either group of employees (contact or care) may experience WPV?	19	No one has a crystal ball! Patients could be mad because the room was too hot or too cold. Patients could be irrational. Patients level of tolerance varies so much! If it is day 5 and the patient has had minimal sleep because of every 4 hour vital sign checks, IV pumps beeping, daily lab draws, afraid because you do not know what is happening, painful dressing changes, or receiving a poor diagnosis. How chipper would you be if that was you? You finally fall asleep for an afternoon nap. SCENARIO 1: Your nurse wakes you up to ask if you have had a bowel movement? SCENARIO 2: The housekeeper came in and was taking out the trash and woke you up? I think the reaction would depend on if the patient. It could be the patient would be fair and their reaction would not be based on the person that woke them. UNLESS the patient feels entitled to lash out at a person they feel is menial compared to them.
With specific examples, please describe in detail the types of workplaces or other conditions where the presence of controls prevented, or you believe could prevent, violent incidents involving patient/client/resident contact employees	20	Having tools to mitigate WPV are very helpful. Problem is what do we implement to get the most for our investment? I believe education is important. I have experienced how effective communication can defuse a situation from tense to normal. Thus preventing WPV. Some solutions are not financially doable for small healthcare facilities. Being fully staffed also can make a difference between feeling safe and vulnerable.
Are there any other categories of workers currently covered by the regulatory framework that should be excluded? Why? Please provide specific reasons for including or excluding categories of occupational groups.	20	NO
OSHA seeks feedback from SERs on whether the agency should narrow the focus within the social assistance sector to NAICS 6241 and exclude other industries under NAICS 624. Or should the agency maintain a broad focus and include all industries within the social assistance sector under NAICS 624? Why or why not?	21	For small rural healthcare facilities we have one or sometimes two people in this role. They have to deal with a lot of patient issues and deserve to be included.
Are there industries within the social assistance sector that OSHA has not included that should be covered? Please explain	21	NO

Issue	Page #	My answer
Are the situations in which social assistance workers encounter WPV similar to those encountered by workers in healthcare settings? Does this vary depending on whether these are field-based social assistance services or those provided within a fixed establishment?	21	YES - They may experience it more often because they ask about issues the patient may rather not talk about, like DPOA, DNR, etc.
Do you think it's appropriate to cover both healthcare and social assistance under one standard? Why or why not?	21	YES - These discplines work hand-in-hand to care for the patient. If the situation not good then direct care staff lean on the advise of the social assistance staff. And vice versa.
Should there be different requirements for healthcare settings as opposed to social assistance settings? If so, please identify those requirements and explain your reasoning	21	Both settings deserve to have equal protection because both settings are equally likely to experience WPV.
Should OSHA remove some or all of these field-based sectors—Emergency Medical Services, Home Healthcare, and Field-Based Social Assistance Services—from the scope of the draft regulatory framework, and instead focus upon the establishment-based operations? Why or why not?	22	I do not think it makes sense to remove these groups from this regulation. If anything we have to be creative to be safe in these areas. Home health referrals are a good time to get background information on the patient's mental health, house layout (think about when PT is asking the patient to describe their home environment. this is an ideal time to ask about potenital hazards in the home). Unfortuantly EMS staff do not have the luxury getting infomation ahead of time. They need still think that they do things that are smart they go to scenes with more than one person. They have emergency radios or other communications equipment. Thinking ahead and anticipating potential problems and coming up with solutions is key.

Issue	Page #	My answer
What difficulties do employers in field-based settings face when trying to protect workers from WPV? How do they deal with these challenges? OSHA is particularly interested in challenges that may be different than those faced in facility-based settings.	22	Home health nurses travel on their own to each patient's home. Working alone can make you a target for violence. However being aware of your surroundings, trusting your gut instinct, and always keeping your exit clear and unblocked. Challenges for home health include flat tires, car issues, weather issues (snow, ice, etc), patient's pets, the patient's home condition. Lack of running water, no heat or air conditioning, and poor hygiene practices. Being on call and responding to a call after hours can be stressful. I was driving to the home of a hospice patient that was dying around 1 AM in my car. Over the hill at 60 mph and I hit a racoon. There was nothing I could do it was a rural two lane road with a deep ditch on either side. I could not stop to assess the damage until I arrived at the patient's home. Fortunatly for me it did not do any damage to the car. However if that had been a deer then I would have not been able to make it to the patient's bedside in time.
How can employers ensure that specific assessment and control elements indicated in the draft regulatory framework are implemented in remote settings?	22	Ask their employees if they are doing what is asked of them? If the employee sees it as a benefit to them then they will use it or follow the regulation. If the employee sees no value then they will not follow the regulation. By value I mean how does it improve the patient's experience? Does it make their job easier?
Do you think OSHA's approach to covering employers in field-based settings is appropriate? Why or why not? OSHA welcomes any thoughts SERs have on how to effectively improve safety in these settings, in particular those that minimize the burden on small entities.	22	You have to apply regulations that make sense to the field in which they are being used. You cannot have one set of rules for all. Rules that make sense for home health include - Vehicles used for home health need to have routine maintenance. Home Health nurses need to have cell phones provided and include emergency numbers in the phone. Hospice nurses may carry medications including morphine for dying patients. How does the agency secure the drugs the nurses carry?
What approaches are currently used to protect workers in field-based settings? Are existing controls adequate to protect employees in these sectors? Do small entities typically rely on different controls than larger entities	22	Training and education on situational awareness is important. Planning ahead to overlapping appointments by 15 minutes. That way two people are there and one discpline (nursing and physical therapy, nursing and bath assistant, etc) can hand off to the oncoming discipline. This may not always work. Schedules change if an employee calls in sick or if a patient cancels their therapy appointment.

Issue	Page #	My answer
OSHA is interested in receiving feedback and/or any supporting data from SERs with experience in the provision of medical services within educational or correctional settings on whether OSHA should include these settings under a potential draft standard.	23	Not an area that I am familiar with.
OSHA welcomes input from SERs regarding the risks of WPV associated with healthcare services within correctional facilities and educational settings, and the potential need for options that include these employers within the scope of the draft standard	23	I am assuming many more layers of safety would be needed. Again this is not an area I am familiar with.
OSHA welcomes your thoughts on the draft requirements for a WVPP. Do you think a WVPP is an important component of a WPV Prevention standard? Why or why not	28	What is the difference between a plan versus a policy? We have a WPVP policy. It tells the employees to report incidents of WPV. It instructs employees to use quality data check to report incidents of WPV. Our system annually reviews all policies in our system. TO hold employers accountable I think this has to be part of the requirements.
Do you agree that, if required, the WVPP should be written? Why or why not?	28	TO hold employers accountable I think this has to be part of the requirements.
Are there any elements of the WVPP that OSHA has not considered that you think should be included? If so, what are they	28	Can patient's be held accountable for their actions against the healthcare worker? I know that in some cases, dementia patients, that is not an option. But grown adults should have some knowledge of right and wrong. I understand some of our patients come from broken homes and have suffered in the past. However the actions of others perpertrated against you (the patient) do not give you the right to do the same things to my employees. The patient is the other half of the preventing work place violence equation. I agree we need to have appropriate training and safety measured based on your hazard assessment, but until you hold the patient accountable you are not solving the problem. Many organizations have implemented the measures you have recommended but the incidents and rates of WPV are still increasing. I know OSHA does not have any ability to regulate patients, but you can advocate for us. You can bring this to the attention of your contacts that can pass laws to protect Healthcare workers.

Issue	Page #	My answer
Are there any elements of the WVPP that OSHA has included that you think are unnecessary? If so, what are they? Are there other protections that should be included instead	28	As an employer I want to protect my staff. Can OSHA help provide funding to implement the changes needed for WPV prevention? Without the funding how can employers make these changes? We have to look at each safety item and based off of our hazard assessments and we want to give our employees all the protection available. Unfortuantly there is a limited budget and some interventions can be very expensive.
How do you currently manage the health and safety duties and responsibilities of multiple employers at your establishment?	28	N/A
OSHA is also interested in SERs' perspectives on whether and how multi□employer duties should be specified in a potential rule.	28	N/A
Do you currently involve employees and their representatives in the development, implementation, and review of your WVPP if you have one? If so, how are they involved? Please describe your process of involvement and review. Is this process typically successful in terms of producing a plan that is endorsed by the employer and employees and their representatives?	28	In 2018 all employees were asked to complete a WPV survey. This survey asked them about their perception of WPV in their departments. Most of the staff said they feel safe at work. WPVP committee was meeting regularly until 2020 COVID-19 pandemic. Plans are to start meeting soon.
Do you think OSHA should include a requirement for employee involvement? Why or why not? What benefits or challenges would you anticipate if OSHA were to include this requirement	28	I think it is okay to include employees if they are willing to participate. If an employer has tried to recruit employees and can document their efforts then that should be considered as a pass. In small communities several staff even non-managerial staff are wearing multiple hats and it can be hard to recruit staff to join work groups.
OSHA requests feedback from SERs about these alternatives. Do you think it's necessary to conduct a formal assessment of the WVPP annually? Why or why not?	29	Only if it is supported by an increase in WPV incidents and the policy needs to change to reflect the new safety issues. If an employer is not seeing an increase in reports and no new safety issues are identified then it does not make sense to revisit. Just checking a box at that point.
Do you think employees would be as protected from WPV hazards if the plan was reviewed every other year (biennially), or every three years (triennially)? Why or why not	29	See last answer above.
If you currently conduct a period review of a similar plan, please indicate how often this review occurs and whether the review typically results in changes to the plan	29	Policies are reviewed annually to make sure they remain current and remove any outdated information.

Issue	Page #	My answer
OSHA welcomes SERs' feedback on the potential requirements for hazard assessments. Do you agree that hazard assessments are an important component of a WVPP? Why or why not	34	A hazard assessment is a good tool. It can be a building block, but I want to cultivate other skills for my employees like situational awareness, trusting gut instincts, and maintaining an unobstructed exit. Looking at your areas crime rate will not help in rural communities. We have low crime rates but we still have workplace violence because an everyday Joe can become violent and rude.
Do you perceive the potential requirements for annual hazard assessments to be problematic? Please explain	34	*"A requirement for annual hazard assessments specifies that subsequent hazard assessments take place at least annually and include an assessment of the previous three years of WPV incidents. The draft regulatory framework for hazard assessments also includes a requirement for employers to provide an opportunity for employees to report any previously-unreported WPV incidents that may have occurred in the establishment during the prior three years. Such a requirement would be intended to yield a more robust and effective hazard assessment and would underscore to workers that the reporting of WPV incidents is both expected and required* ." I do not think it is a good idea to allow employees to report previously unreported incidents for a few reasons. 1. Time dulls memory. Facts may become distorted and employees may not include key things that may have contributed to the event. 2. Employees may file a report that was not true. It would be difficult to determine what happened. Employee turnover is high and If the witnesses to the event were no longer employed and unable to give their testamony. 3. How can an employer do a corrective action if the event happened over three years ago? It creates more work for the employer that cannot be verified for accuracy .
Do you think OSHA's estimate that the hazard assessment will take 20 minutes per bed (or bed-equivalent) is accurate? If not, what do you think would be a more appropriate estimate? What do you expect would need to be done that would take that amount of time	35	Depends on the case. If the person is young and does not have a long health history then 20 minutes may be an appropriate amount of time. If the person is a sixty year old adult with multiple health issues, with minimal resources, and debt then 20 minutes is not sufficent. LOOK AT THE PATIENT. What is driving our patients to act out? Long ER wait times? Insurances that over promise and under deliver? Family issues - divorces, kids, finances.
Should the provision for reporting previously-unreported incidents be included? Why or why not? Do you perceive any difficulties arising from such a provision? Please specify	35	NO - I do not believe that this will yield accurate information. See above for additional comments. Also if a person did not report at the time of the incident it may be because they do not want to tattle on their patient.

Issue	Page #	My answer
What type of information about crime in the surrounding community is typically provided to employees? Are there specific steps that employees are encouraged to take for their safety when arriving at, or leaving, a facility? When there are patients or clients identified as potentially posing a risk to staff, are there specific measures to limit or otherwise address interactions with those patients or clients in the outside areas surrounding the facility?	35	If there is a known threat the police department will contact us and let us know if there has been an incident that may impact us. We are told to call the police if the suspect were to arrive at any of our locations. When leaving work employees are encouraged to be alert and aware of their surroundings. Our facilities are small and parking is easy walking distance to the main buildings. If there is a potential threat we can lock down and close our facilities to protect our staff. We have WVP training upon hire and annually. We also had training for run/hide/fight with walk throughs at all locations to determine areas that needed to be improved.
Are the level and types of crime in the employer's served community are relevant risk factors for employers to evaluate as an element of their workplace hazard assessment? Why or why not? If OSHA requires assessment of crime in the surrounding community, are there specific measures you recommend for this purpose?	35	This would not benefit small rural healthcare providers with low crime rates.
Are there other factors that OSHA should require employers to consider, either in establishment-based or field-based hazard assessments, that are not included in this draft regulatory framework? If so, what are they and why do you think they are important?	35	YES - Patient's access to inaccurate and potentially harmful information on online platforms. Patients are using google to do research and finding answers that may conflict with the recommended treatments. During COVID-19 we had family members become very upset if their loved one was turned down for treatment. Even after the Medical Provider explained to them that the treatment would not be helpful. Taking IVERMECTIN for COVID-19 illness comes to mind. Another option is looking at the patient's medical history. Patient's mental status and cognitive functioning. Is patient expressing frustration and complaining about pain or lack of answers to their questions? Why are patient's less curteious? Patients used to respect medical providers and now that seems to not be the case.

Issue	Page #	My answer
OSHA believes that patients and clients (and their families or other legally designated decision-makers) are sometimes required to agree to provide a safe environment for home healthcare employees as a formal condition of receiving home healthcare services. Does this align with your experiences? What happens if such agreement is in place but employees have concerns about the safe environment upon arrival? Have WPV incidents, or situations that appeared to be moving in that direction, occurred in locations with those types of agreements? Are there other measures that OSHA should consider to protect employees during visits to provide services in the home of a patient or client?	35	YES - one case we had a home health patient had multiple outdoor dogs. The patient was instructed to lock up dogs before the therapist or nurse arrived at her home. Patient was instructed on arrival times but still failed to secure her animals. Therapist was bitten by one of her animals. The bite caused a bruise but did not break the skin. We had a plan to address the concern. Patient was given tools but was not compliant. Because of the bite the patient was told that next time the nurse or therapist would not leave their vehicle until the animals had been secured. Another concern in rural areas for home health providers is poor cell phone coverage. We need more cell phone towers to increase signal strength. Just a suggestion, instead of looking at crime levels in our communites (which would not be helpful to rural healthcare). I suggest OSHA creates a one page tool that determines if a patient is low/medium/high to exhibit WPV behaviors. The tool should include things that can cause stress. It can ask are their financial issues, marital issues, job issues, depression or anxiety, recent deaths in the family, etc.
In your experience, do employers of home healthcare workers and field-based social assistance workers typically ensure that all of the hazard assessment and control measures in Table E-1 are implemented? Why or why not? If not, do you have recommendations for how to improve employer use of hazard assessments in these settings? Are there particular obstacles to implementing assessments?	36	Table E-1 (page 211) is for fixed location sites not home health care workers.
What are current practices for hazard assessment in this sector? Are such elements already generally considered? What protections and controls are generally implemented? Are there any additional hazard assessment or control measure elements that OSHA should either add or remove from Table E-1 with respect to home healthcare workers?	36	Table E-1 (page 211) is for fixed location sites not home health care workers.

Issue	Page #	My answer
Is it reasonable to expect employers of emergency medical services workers (or firefighters cross-trained in EMS) to ensure that all hazard assessment and control measures in Table E-2 are implemented? If not, are there some elements you believe can and should be adhered to? Which ones are these and why?	36	In rural areas we are lucky if we have a local volunteer EMS unit. Some of our EMS teams may be forced out because they do not have the funds to pay for training. In rural areas how could a person that attended a WPV seminar then go and train their EMS crew. Or would it have to be a certified trainer? I hope you would allow a person that was recently trained pass along what they learned to the volunteer EMS. I do not know how you would document it or what would qualify as adequate documentation.
What are current practices for hazard assessment in this sector? Are the elements in Table E-2 already generally considered? What protections and controls are generally implemented? Are there any additional hazard assessment or control measure elements that OSHA should either add or remove from Table E-2 with respect to emergency medical services workers?	36	EMS typically responds to calls as a team. EMS workers are very good at assessing the area for safety concerns. EMS is in contact with dispatch and can request help if needed.
Would the hazard and control elements in Tables E-1 (for Home Healthcare and Field-Based Social Assistance) and E-2 (for Emergency Medical Services) in the draft regulatory text ensure a higher-degree of worker protection than what currently exists in these industry sectors	36	Table E-1 (page 211) is for fixed location sites not for EMS.
Are there additional requirements for hazard assessment or controls for Tables E1 or E-2 in the draft regulatory text that OSHA should consider? Are there specific requirements that OSHA should consider removing?	36	Table E-1 (page 211) is for fixed location sites not for EMS.
Does your establishment operate or contract with non-emergency transport services for patient/client/resident purposes? Please describe these services. Is it appropriate for OSHA to consider such transport services for inclusion to a potential future proposed rule?	37	YES. Our healthcare facility provides transportation for our hospital patients and LTC residents to an from medical appointments. It is getting harder to find drivers that want to transport frail elderly. This would be a burden for healthcare facilities to provide fi they cannot find drivers.
OSHA requests feedback from SERs about this alternative. Should OSHA require the assessment of three years of data on WPV incidents or would a review of one or two years of data be adequately protective? Why or why not?	37	What is the benefit to the review? If we make changes to policy when events happen and those changes mitigate the risk. So then why do we have to do three year look backs? We do not have enough incidents reported to justify the three year review.

Issue	Page #	My answer
OSHA requests feedback from SERs on this alternative. Would it be beneficial to employers and improve employee safety and health to not have designated high risk service areas but rather focus on all aspects in all areas of the facility? Why or why not	39	High risk service areas should get additional attention and protection. Other areas need to practice situational awareness. We have seen that violence can take place in parking lots and in the ER. Sometimes it is the opportunity and not the location that makes it easy to commit violence. IN RURAL AREAS we are all at higher risk because targeted staff are more accessible to the people that want to do us harm. There are no metal detectors or security personnel. We use the same common areas as our patients. I would love to have metal dectectors and security personnel at all hospitals. The goal would be to say to criminals there are no easy targets at hospitals. We are going to prevent you from bringing weapons into our spaces and targeting our employees and patients.
OSHA welcomes feedback from SERs about this alternative. Would you prefer to be able to define a high-risk service area for your facility? Or would you prefer OSHA offer some parameters for which areas should be considered high-risk? Please explain.	39	I think it is okay for OSHA to include parameters for what constitutes a high risk area. I would not want a pre-determined list of high risk areas. I want to take the recommendations and apply them to areas that OUR data supports the high risk category.
Should OSHA adopt this alternative and allow employers to forgo the full hazard assessment for areas not designated as high-risk service areas (as determined by review of incidents)? Why or why not? Would this be as protective for workers?	39	I don't know. I have told employees to report WPV when it occurs. I believe that more WPV happens than what I am getting reports for. So I would say we need the hazard assessments. It would be beneficial if the hazard assessment could be completed with 15 minutes. Any longer and staff will not complete them.
In Control Measures paragraph (e)(1)(ii)(F) and in Tables E-1 (for Home Healthcare and Field-Based Social Assistance) and E-2 (for Emergency Medical Services), OSHA has contemplated requirements such as implementing effective incident response procedures. These include standard operating procedures for obtaining assistance from the appropriate law enforcement agency during all work shifts. * OSHA seeks SER input on how and if this is a current or prevalent industry practice. In which circumstances is such assistance is sought? How often would you say such assistance is sought?	44	Employees are encouraged to call 911 if they feel that they are not safe at work. If a patient is violent we have panic buttons. It does not happen often that we have to contact the police to intervene in a WPV situation.
*Are there any circumstances where obtaining assistance from the appropriate law enforcement agency is specifically inadvisable?	44	Not that I know of.

Issue	Page #	My answer
* Overall, do you think this requirement is appropriate to include in a potential WPV Prevention standard? Why or why not	45	All employees should know what to do if they feel unsafe. This is an appropriate measure.
OSHA seeks feedback on this potential requirement. What types of visual cues are currently used in the healthcare and social assistance sectors? Do you use any types of visual cues in your facility? Have you found such cues to be helpful in reducing the risk of WPV?	45	
Do you think it's appropriate for OSHA to include a requirement on communication of patient/client/resident history or potential for violence in a potential WPV Prevention standard? Why or why not	45	I think it is important to have that information accessable to the providers. Some electronic health records are better than others when it comes to the ability to monitor WPV history. Rural and or small facilities may be at a disadvantage because our health records may not be able to do what larger facilities can do.
Are there specific approaches that OSHA should require or, conversely, not include, in a potential WPV Prevention standard? Please explain	45	Add flexibility for smaller organizations. Can organizations opt out of a portion of the regulation if we have the data to support that we do not meet the criteria? We have unique challenges and the measures we implement should add another blanket of security for our employees. Sometimes it feels like we are checking boxes.
OSHA welcomes SER input on this potential requirement. To what extent do the healthcare and social assistance sectors currently communicate a patient/client/resident's history or potential for violence **to external healthcare providers**? How is this currently done?	45	Currently an external provider is sent a referral with the referring providers notes. Provider may note if a patient has issues with depression or anxiety. I believe it is prudent to include in the note if the provider witnessed the patient's violent behavior or if the patient reported violent behavior.
Do you think this is a requirement OSHA should include in a potential WPV Prevention standard? Why or why not?	45	I think it would be difficult to satisify this requirement. Sometimes people can be grumpy if they do not feel well. We will need a clear definition of WPV in order to cmply with this request. Would this go both ways? IF a patient became violent with the external provider would he/she have a requirement to report that back to the internal medical provider.
Would this requirement provide a meaningful extra layer of protection for workers from WPV? Why or why not?	45	Yes. It may heighten employees situational awareness and it may make the difference between getting hurt and walking way unscathed.

Issue	Page #	My answer
If OSHA includes such a requirement in a standard, how could OSHA mitigate privacy concerns, if any, while still protecting workers from violence?	46	There are already fines for violating a patient's privacy, aka HIPPA. I do not think additional fines are needed. Employees are educated on the importance of HIPPA and to avoid discussing patients and their health concerns outside of work.
OSHA requests feedback from SERs about an approach, such as OSHA contemplates in Alternatives # 1, 1(a), and/or 1(b) above, that would require employers to address WPV through development of a plan, employee participation, training, recordkeeping, and evaluation, but that would not require the employer to implement engineering controls or administrative/work practice controls. Do you agree with this approach? Why or why not?	47	No. I think that staff deserve to feel safe at work, and you cannot rely on historical data. Because we know that our society norms have changed, and our employees are at risk. I want to believe that healthcare facilities are willing to make adaptations that provide protection to the staff. For example - during a walk through of our location with a mindset of Run, Hide, FIght, it was noted that there were unsecured access points. Patients could gain access to areas of the clinic or hospital that they should not have access to. We secured those entrances with badge or key pad access. It will keep staff safe by limiting access to areas so only staff can use them.
Would this approach reduce the risk of WPV incidents and protect workers to the extent that no other controls would be necessary? Please explain	47	No, I believe that we need to do everything possible to protect our employees. I think that the biggest bang for our buck is to invest in education. Training our employees on situational awareness and signs to look for in a patient that is going to become violent are very important. I do not want my employees to let down their guard thinking they are protected because we have seen patients break through barriers to committ violence.
Are there specific measures that must be included in a WVPP to ensure the plan and training provide the same protection for employees that would be provided through specified environmental, engineering, and administrative/work practice controls	47	Situational awareness training is a must have. Reading a patient's body language and knowing what actions reflect anxiety and frustration can be helpful. De-escalation training is helpful if an employee recognizes the patient or visitor is tense. These are things that every facility should be able to do.
Are there specific engineering or work practices that you perceive as less effective in preventing WPV than others? If so, which should OSHA include, and which could be eliminated without decreasing employee protections? Please explain your thinking	47	Sometimes having engineering controls may lead to frustration. We have deep registration desks and some of our elderly hard of hearing patients cannot hear the registration clerk instructions. Because of the distance between them. This can lead to frustration and that can turn into violence if left unchecked. There has to be a compromise between making everything safe and being practical.

Issue	Page #	My answer
Are there workplace violence prevention control measures (administrative controls, engineering controls, PPE) that have been implemented at your establishment which have been found to be particularly effective or impactful? Are there any supporting data you can point to either from your own establishment, in the literature, or elsewhere?	47	Education on situational awareness. Several team members did a walk through of our organization and came back with recommendations to increase security. Installing key pads or badge entries have been the most common.
Are there specific environmental or engineering controls that OSHA should require in some or all covered settings? Which engineering controls are the most impactful in protecting workers? Are there any settings where OSHA should mandate the use of specific engineering controls?	47	Limiting access to provider's offices and exam rooms can help. Each facility will need to do their own hazard assessment and determine what steps are needed to protect their staff. You could make allowances or tiers what would be required of a large healthcare facility may be different than what is required of a critical access hospital. For instance, a critical access hospital that does not staff a security team would not benefit from a metal detector. On the other hand a larger facility with a security team would benefit from a metal detector.
OSHA expects that no patient/client/resident contact-only employees will need to participate in the intermediate training	50	This statement came from page 50 and I think it is absolutely wrong. Our business, registration, and HIM staff run into this on a daily basis. People in these areas should be included in intermediate training.
OSHA welcomes feedback on the potential requirements for training. What is the minimum amount of employee and manager training necessary for addressing WPV? Do you agree with OSHA's designation of different levels of training for different types of employees? If not, how should OSHA realign these groups? Are there employees who you think will need more training than OSHA is requiring? Or any that could receive less training without affecting their level of protection from WPV	53	I agree that training should occur upon hire and annual refresher courses are needed. I think that this should be a multi-layered approached. What would work for a large 10,000 employee healthcare facility will be difficult to implement for a 500 employee healthcare facility. At our site we provide a course on WPV prevention on Relias for our staff and we provide a course on run/hide/fight on Relias. All employees are required to take both classes upon hire and annually. For a critical access hospital our patients interact with different staff. I think it is key that everyone has the same training regardless of if you work in a designated high risk area.
Has OSHA included the correct topics in each category of training? Are there additional topics that should be covered or are any of the topics included in the training requirements unnecessary	53	I did not find any topics mentioned. What does OSHA want taught to our employees? We teach about situational awareness and run/hide/fight.

Issue	Page #	My answer
OSHA welcomes comment on whether your facility does or would provide advanced training to some employees as OSHA has discussed above. Do you think it's important for some employees to have this advanced level of training? Alternatively, do you think all employees should receive this kind of training?	53	Depends on what is included in the required training? OSHA has not said what topics need to be included? OSHA has only said that certain people may need more training based on patient interaction. Which is not the end all be all for workplace violence. WPV can occur anytime and anywhere. A patient may act out in radiology during their CT scan because they are cold, hungry and scared. A patient may act out after receiving anesthesia. We sent several employees to learn about hands on defensive manuevers that can be used to protect ourselves. This education was offered to nursing, LTC, clinic, etc. Violence can happen anywhere and it is important that all employees get the same education.
Do you anticipate that you or others in the potentially regulated community will train employees to be able to train others in their facility. Why or why not?	53	Depends on what is included in the required training? OSHA has not said what topics need to be included? OSHA has only said that certain people may need more training based on patient interaction. Which is not the end all be all for workplace violence. WPV can occur anytime and anywhere. A patient may act out in radiology during their CT scan because they are cold, hungry and scared. A patient may act out after receiving anesthesia. Can the training can be done via Relias or Healthstream then it is easier to get the staff the same training. We have used train the trainers in the past when we have to educate a lot of people in a short amount of time.
Are OSHA's estimates of the costs of outside trainers and in-house trainers accurate? Why or why not? Is there a way that OSHA could structure training requirements to reduce the costs for trainers	53	Unsure. It may be more costly for a rural area because of travel costs to get to the training. Also if the employees would need accomodations to spend the night away from home is an additional cost. Providing computer courses would be easier to provide to employees.
OSHA estimated that 100 percent of patient/client/resident care employees in behavioral health settings, 45 percent of residential care patient/client/resident care employees, and 20 percent of patient/client/resident care employees in other settings (hospitals, long term care, EMS, social assistance, etc.) participate in the intermediate training. Do you agree with these estimates? If not, what do you think would be more appropriate?	53	I do not agree with the estimates OSHA has provided. I believe that anyone employed with a healthcare organization should be given WPV prevention education. In smaller organizations if a WPV event were to happen we rely on other staff from other areas to respond to the site to provide strength in numbers. It is important that all staff have the same education so they understand what they are responding to and how they can be of the most assistance.

Issue	Page #	My answer
OSHA welcomes SER feedback on the training time estimates. In your experience, do you think the original training time estimates of between 2 and 24 hours were reasonable? Why or why not? Or should OSHA use different estimates for any or all categories of worker training? If so, what do you suggest? What is the basis for alternative estimates	54	I do not agree with the estimates OSHA has provided. I believe that anyone employed with a healthcare organization should be given WPV prevention education. In smaller organizations if a WPV event were to happen we rely on other staff from other areas to respond to the site to provide strength in numbers. It is important that all staff have the same education so they understand what they are responding to and how they can be of the most assistance.
Do you agree that the most extensive level of training could be completed in eight hours? If not, how much time do you think is necessary to cover the topics discussed above that would be covered by the most extensive training?	54	Unsure because OSHA has not specified the topics that have to be covered in that amount of time.
OSHA requests feedback from SERs about these alternatives. Do you think training should be required annually? Why or why not?	56	Because of high employee turnover in many departments. I think it is necessary to have annual training for all employees.
Is there an alternative schedule besides annually on which you think employees should be retrained on WPV prevention? If so, please specify	56	No, Training upon hire and annual training are sufficent. Unless an incident happens and we need to update everyone before the annual update. I think having occasional, not mandated, updates allows each facility to tailor this to their needs.
Are there types or groups of employees who should be retrained less or more frequently than annually? If so, please specify which groups and how frequently you think training needs to occur for those groups. What is the basis for your recommendations	56	No, all employees need annual refresher.
OSHA welcomes SERs' thoughts on requiring extensive training for some groups of employees. Do you think OSHA should require some or all workers at some or all establishments should receive advanced practical training in de-escalation, chemical and physical restraints, and all standard operating procedures of the response team? Why or why not?	56	I think all employees need to have the same education. Except chemical and physical restraints that has to be LTC nursing, acute nursing, and providers because of the strict monitoring requirements and ability to give a patient a medication for agitation.
OSHA welcomes comments on the potential violent incident investigation and recordkeeping requirements. Is a violent incident log a useful tool for understanding and mitigating WPV hazards? Why or why not?	60	We are already doing this. Most cases of WPV when a patient is aggressive and hurts an employee it is because the patient has **dementia.** When I ask the employee what could be done to prevent the injury the employee will say nothing. The patient is not aware of what they are doing. Dementia is the most common cause of WPV in our facility.

Issue	Page #	My answer
Are there obstacles to investigating within 24 hours? If so, what alternative time frame for the investigation do you recommend and why	61	Staff that do the investigation are typically not here on weekends, holidays, and at night. I would say that 24 hours can apply M-F but there needs to be some allowances for holidays and weekends. DEPENDING on the severity of the incident. If the incident is minor and the employee can still work then the investigation might be delayed. IF the incident causes the employee to become unable to work due to injury then we need to start the investigation sooner.
OSHA's draft regulatory framework states that the violent incident log should include, among other things, the nature and extent of the employee's injuries; the date, time, and location of the incident; the job titles of involved employee(s); a description of circumstances at the time of the incident; and a classification of the person who committed the violence (e.g., patient, coworker, stranger, etc.). Do you agree that these are the necessary and appropriate details to include in a log? If not, which do you think should be eliminate? Should any be added?	61	I think that the things listed are all important and need to be included in the log. I would also include was the patient impaired? (i.e. drunk, high, has dementia, etc)
Do OSHA's estimates of incident frequency and investigation time line up with your experiences? If not, please provide details on how OSHA should adjust these estimates	61	We average 4.5 WPV reported incidents every year since 2018. I believe that number is low.
Are OSHA's assumptions about costs for recordkeeping and retention of records reasonable	61	yes
OSHA welcomes SERs' thoughts on these alternatives. Should OSHA require incident investigation for only incidents that either involve physical assault or require medical care beyond first aid? Why or why not?	62	All violent acts should be investigated. You cannot ignore verbal abuse. Because being called names and verbally abused should not be tolerated by health care providers. Also verbal abuse can be a predessor to physical abuse. Verbal abuse can also lead employees to burn out and dissatisfaction with their jobs.

Issue	Page #	My answer
Is there an alternate distinction OSHA should make on which incidents should be subject to incident investigations? If so, please explain.	62	Investigations can be difficult. It can become a patient said vs employee said situation. All incidents should be investigated. However it depends on how much information is provided to the investigator. Without details it can be hard to conduct an investigation. The goal is to help our employees feel safe and appreicated for their hard work. If the patient or family member is verbally abusing our employees what happens to the patient or family member? How will they be held accountable for the physical or verbal abuse they committed on my employees? You are only asking about 1/2 of the problem. Why are the patients/visitors/family members committing these awful acts against healthcare employees?
Do you think OSHA should require post-incident medical treatment? Why or why not?	62	Would this be covered under workers comp? We send WPV incidents to our workers comp vendor. Instead of making a separate requirement, can OSHA direct healthcare facilities to use the existing workers comp to help injured employees?
Do you think OSHA should require post-incident mental health treatment? Why or why not?	62	Mental health services can be difficult to find. This would cost more than what OSHA has determined because rural areas have to travel further sometimes 3-4 hours to get to medical providers for mental health. Sometimes the wait periods to be seen can go into months. Our facility has an EAP program that provides limited counseling services to our employees. Three free sessions are provided per 12 month period. This would not satisify the weekly for one year requirement that OSHA is proposing.

Issue	Page #	My answer
What concerns, if any, would you have about OSHA including such a requirement for either medical treatment or mental health treatment, or both?	63	I believe we can cover the medical treatment with our current work comp program. I TRULY BELIEVE THESE SERVICES ARE VALUABLE AND DESPERATELY NEEDED. However, our country is facing a mental health crisis. We do not have access to mental health providers currently. This would create additional burden to the facility. Your cost estimates are not accurate. As I said above it can take 4 hours of driving time (one-way) to reach a mental health provider. **Gas prices of 3.50/gallon. If a car makes 22 gallons/mile that is approximately $77 in fuel expense for one round trip to see the mental health provider. That does not include missed time from work, wear and tear on the vehicle, meals, etc. If an employee went one time a week for a year the fuel cost would increase to approximately $4,000. For one employee to drive to a mental health appointment weekly for one year. Telehealth could be the solution. However most staff that I talked to want to have in-person help.**
What benefits would mental health treatment provide to worker health and to you as an employer? Do employees typically receive time off from work following a WPV incident? Is it common for employees to exhibit signs or symptoms of mental health problems (depression, irritability, absence from work, etc.) following a WPV incident? Are you aware of instances where employees have left their jobs or requested a transfer to a different location or job duty following a WPV incident?	63	We have an Employee Assistance Program and have partnered with Vital WorkLife to provide mental health services to our employees. Vital WorkLife provides a wide range of benefits including three counseling sessions per episode. I have no doubt that employees can have negative side effects after experiencing WPV. However being a rural facility we have had ex-employees return to work for us because they did not feel safe in larger metropolitan healthcare facilities. One employee mentioned she was working at a larger facility and was put into a choke hold. She was concerned for her safety and took a pay cut to take a job at a site where she felt safe.
What type of post-incident medical treatment and/or mental health evaluations and treatment are typically available to workers? Do entities that provide these types of treatment programs typically experience more or less job turnover in affected job positions than entities that do not provide these programs?	63	When an employee reports a WPV incident they are recommended to check out the EAP, Vital WorkLife. I have helped staff download the Vital WorkLife app on their phone for easy access. Employees would have to come to me and tell me they are using the App. Otherwise I would not know who is using the app due to privacy issues. The turnover we see has not changed since I started in my position over six years ago.

Issue	Page #	My answer
If you have implemented post-incident medical and/or mental health evaluations and treatment, OSHA would be interested to hear your experiences. How do these services work? What has been the cost associated with these programs? Have you seen a benefit to your workers?	63	The WPV physical incidents we have received have not required more than first aide. I have encouraged staff to sign up for the EAP Vital WorkLife program. Employees that have used the Vital WorkLife program and told me about seem to like it. The cost is minimal because it can be done via a phone call or face time. No travel expense.
In the PIRFA, security staff have been classified as patient/client/resident contact employees. Is this an accurate categorization? Should security staff (when available in covered establishments) be classified as patient/client/resident care staff? Should security staff be considered as a separate category altogether	63	N/A we do not have a security staff in our facilities. If we did I would put them as patient/client/resident contact employees
What is the current role of security personnel in the management of workplace violence incidents? Are they responsible for physically responding to WPV incidents, or are they primarily responsible for observing and reporting to police or other authorities? What role does security personnel serve with respect to workplace violence recordkeeping and incident investigation at your facility?	63	N/A we do not have a security staff in our facilities. Our facilities include a critial access hospital, two long-term care locations (in different Kansas counties), one assisted living, and six health care clinics (located in 4 different Kansas counties).
Does each entity typically have dedicated security personnel, or are some employees with other responsibilities also tasked with providing security? Are designated security personnel typically contracted from a security firm, or direct employees of the entity providing health or social services?	63	We do not have a security staff in our facilities. We do not contract with a security firm.
What kind of training do security personnel receive in order to manage these situations? If the security personnel are employees of a contractor, who provides their training? The contractor, the health or social services provider, or both?	63	N/A

Issue	Page #	My answer
Should security personnel be covered under OSHA's contemplated training requirements? Or would it be more appropriate for OSHA to treat security personnel as if they are already receiving sufficient training and equipment to protect themselves during WPV incidents such that OSHA's standard should be focused on the involvement of security in protecting other workers (e.g., ensuring that security personnel are trained to coordinate with other employees as part of a WVPP)?	63	What happens if a facility does not have a security team? Would they be exempt from this requirement?

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April 7, 2023

Andrew Levinson
Director
Directorate of Standards and Guidance
Occupational Safety and Health Administration

Docket # OSHA-2016-0014

Dear Mr. Levinson:

I recently had the opportunity to review the potential standard on Prevention of Workplace Violence in Healthcare and Social Assistance as a Small Entity Representative (SER) and a participant on a Small Business Advocacy Review (SBAR) Panel. I appreciate the opportunity to review the proposed standard and to interact with other members of the SBAR panel. I especially wish to recognize Bruce Lundegren from the SBA and Jessica Stone from the Occupational Safety and Health Administration (OSHA) for their guidance and facilitating the participation of the SBAR Panel members.

I am the owner and operator of a small assisted living facility which serves up to fifteen residents. We currently have a total staff of 11 employees including 2 who are part-time, so we fit the definition of a very small provider referenced in the proposed standard. I am also chair of the National Center for Assisted Living (NCAL), which represents over 5,000 assisted living communities of all sizes across the country, so I am aware of the impact that the proposed standard would have on communities of various sizes as well.

After reviewing the standard and seeking feedback from some of my colleagues across the country, I have several concerns that I would encourage OSHA to address.

1. **The cost estimates outlined are too low.**

In response to Section V: Cost Estimates tables, OSHA uses bureau of labor statistics (BLS) data from 2019 to estimate wages and total labor rates. Normally, those 2019 figures would be an accurate proxy for actual cost of implementation. However, due to COVID, all of my operating

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costs have increased more than normal in the past three years. As an example, my labor costs have increased by 40% in the past three years alone.

In addition, the assumptions of time/resource intensity for elements of this standard are underestimated. For example, the standard hazards assessment calculation of 20 minutes per bed is not realistic for all providers. There is a minimum amount of time for any facility to conduct this review, no matter what size. So, for very small providers, such as those with 4-6 beds, this will be significantly more expensive than what is outlined.

It appears several of the cost assumptions are based on time estimates that are not feasible. For example, OSHA estimates that it would take a small facility such as mine .11 hours, or 6.6 minutes, to conduct a three-year incident review. In my estimation, any of the tasks outlined would require a minimum of .25 hours or 15 minutes. I suggest that the time estimates be revised in increments of no less than .25 hours. OSHA must update these cost assumptions to reflect true costs.

Finally, in smaller facilities such as mine, this standard will be even more challenging and have a larger overall impact. I do not have separate staff or departments such as legal, finance, or human resources. Thus, many of these tasks would fall to me to complete. The total cost of compliance for a facility of my size, per the OSHA estimates, is $1,861. I estimate that, due to price inflation and actual time to complete the tasks, the cost to my business would easily be ten times that much. This would have a significant negative effect on the financial viability of my business.

2. OSHA needs to provide adequate resources to assist facilities, of all sizes, with any compliance.

To help alleviate the burden placed on employers and the overall cost of implementation, OSHA should provide resources to help healthcare and social assistance organizations implement this standard. Resources should include an optional template or outline of a workplace violence prevention program, potential (optional) controls providers can consider implementing along with research showing the impact each control has, and optional training courses. I have used such templates in the past and found them to be extremely helpful for an employer of my size with limited or no in-house training resources. OSHA should provide the training or training materials at no cost so employers are not required to contract with outside trainers. I would much rather use such resources to do the training in-house rather than having to hire an outside trainer who would be unfamiliar with the unique setting and risks of my business.

3. This standard should be modified to reduce prescriptive elements and recognize existing actions providers are already taking that would meet the intent of the standard.

This standard has been written for providers across the healthcare and social assistance sectors. This includes an extremely wide range of provider types. Workplace violence risk will vary

greatly between these providers, and what is required to implement an effective standard will be unique to each provider type. A plan customized to a particular business size and type would be much more effective than a prescriptive, "one size fits all" approach.

I encourage OSHA to consider re-writing the standard, or implementing the various regulatory alternatives outlined (as noted in comment #8 below), to reduce prescriptive elements of this rule and instead provide resources and education to allow providers to develop effective workplace violence approaches for their setting. Many facilities already have policies and procedures in place that could meet the intent and purpose of the standard, and these should be considered as meeting this standard.

The standard should allow providers to document their existing actions that would meet the intent of the standard. For example, in my facility we already do several things to reduce the exposure of our workers to workplace violence incidents. These include screening all prospective new clients for violent behavior and denying admission if there is such a history, training all staff on de-escalation skills and how to deal with angry or combative residents, dealing with residents who have dementia (since dementia is present in many of our residents), monitoring the use of psychoactive medications by our residents, investigating all incidents of actual or threatened violence towards a staff member, discharging residents who behave violently towards staff or others, use of "walkie-talkies" between staff on duty, and training staff regularly on general safety and security of their surroundings at work.

4. OSHA should eliminate the requirement that employers monitor crime as part of the hazards assessment.

Although I support the concept that providers should complete a hazard assessment, as referenced in Section IV and V: Hazard Assessment, the requirement to monitor crime raises many questions, such as how providers are to gain this information, how the "local area" is defined and how often the information should be updated. A small provider such as myself does not have extra employees to manage the ongoing communication that would be required to monitor crime in the "local area." This has the potential to become a distraction from more pressing hazards, and dilute the focus of the standard, which I believe is meant address violence that occurs in or on the provider's premises and primarily from customers/clients.

5. Many of the proposed controls are too prescriptive and would detract from a facility's home-like environment or conflict with local and state regulations already in place.

In response to Section IV: Control Measures, while I support the fundamental idea that the use of control measures to address identified workplace violence hazards or risk factors is important, facilities should be allowed to implement controls that are specifically suited and appropriate to the setting and risk related to the residents served. Overly prescriptive controls that are inappropriate to the setting can be ineffective at protecting employees from violence.

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There are specific controls proposed that raise significant concern and at times run contrary to other regulations or standards of practice. For example, some of the proposed controls would significantly detract from a facility's ability to create a homelike environment for residents. In my setting, our clients choose us specifically because our facility is home-like and non-institutional. Requirements to fasten and secure furnishings, add mirrors in all corners, cameras, and monitoring systems, would result in a facility feeling more institutional and interfere with dignity and privacy that the staff in these facilities are required to maintain and that our residents value. Creating a physical barrier between employees and residents detracts significantly from a homelike environment and from the physical touch that many of our residents thrive upon.

In some states, assisted living regulations also conflict with proposed controls such as surveillance systems or alarms.

The Home and Community Based Settings (HCBS) Final Rule for HCBS providers (assisted living) makes it mandatory for providers to allow residents to have lockable doors, and to furnish and decorate their unit with their own belongings. So, it would be contrary to this requirement for providers to monitor a residents private living space and those spaces should be excluded from the overall hazard plan.

The inclusion of staffing patterns in the control section also poses a conflict with existing regulatory requirements. Many assisted living communities adhere to state regulatory requirements regarding staffing. To include a requirement on staffing patterns may run contrary or create confusion with a facility's other regulatory requirements.

The inclusion of requirements to engage law enforcement may be inappropriate for the population that we serve. Some instances of violence may occur that do not require intervention by local law enforcement, such as violence posed by a resident with dementia. The notification of police for a resident with dementia could potentially be detrimental to resolving the behaviors with the resident. Most assisted living facilities already have reporting responsibilities, including reporting to law enforcement when appropriate. Adding another layer of regulation would confuse the issue and burden law enforcement.

6. The training requirements should be focused on employees with the most direct resident care, and be required of the individual's employer, not host employer, and honor existing training programs.

In response to Sections IV and V: Regulatory Framework relating to Training, training requirements should remain focused on employees with routine direct resident care. The requirement for host employers to ensure that other employers on-site adhere to the workplace violence prevention plan (WVPP) creates logistical and practical challenges. We frequently have staff from hospice and home health agencies in our facility. They regularly work in multiple facilities and subjecting them to multiple different trainings on workplace violence would be ineffective and a waste of resources. This duplication and administrative burden can be eliminated by requiring the contracting or agency employer, rather than the "host", to provide the education to their own employees.

I support the idea of requiring training for those employees identified as providing routine direct resident care or the highest risk of violence. Another more practical alternative would be to require training for all employees upon hire, but annually thereafter only for those employees identified as providing routine direct resident care or the highest risk of violence thereafter.

7. Providers should be allowed to use existing record-keeping practices, including OSHA's 300 logs.

Employers are currently required to keep a list of workplace injuries in the OSHA 300 logs, so the proposed recordkeeping requirements in Section V: Recordkeeping and Retention of Records, including additional workplace violence recordkeeping log, incident investigation procedures, and program evaluation will be extensive and a duplicative added burden to providers. The OSHA 300 log could easily be adapted to record incidents of workplace violence.

8. Many of the alternative approaches posed by OSHA make good sense, especially for smaller providers.

I appreciate that several alternative approaches are outlined in Section VII of the proposal. Adoption or allowance for use of these alternatives would resolve many challenges I have identified. These include:

- Scope: Alternative #1 (pg. 225): Standard applies to "patient/client/resident care" only – not "patient/client/resident contact"; Exempt patient/client/resident contact employees from scope of the rule.
- WVPP: Alternative #1 (pg. 232): Alternative timing of program review (e.g., every two years, every three years vs. annually), would be more appropriate especially for very small providers with low numbers of incidents.
- Hazard Assessment: Alternative #1 (pg. 233): Annual hazard assessments consider one year or two years of incident data, rather than three years of data.
- Hazard Assessment: Alternative #3 (pg. 263): Change the definition of high-risk service area -- No requirement for employers to conduct hazard assessments based on OSHA's pre-determinations of high-risk service areas; hazard assessments would be directed to employer-defined high-risk service areas only. For a very small provider, a single incident could otherwise unnecessarily define a high-risk area by default.
- Control Measures: Alternative #1 (pg. 237): Require only hazard assessment, workplace violence prevention plan, incident investigation, and training.
- Control Measures: Alternative #2 (pg. 238/9): Removal of requirement for all employers to develop standard operating procedures for mass shooter/mass casualty incidents.
- Training: Alternative #2 (pg. 242): Require annual training only for those employees with direct patient/client/resident care and violent incident response duties.
- Violent Incident Investigation: and Recordkeeping Alternative #1 (pg. 245): Requirement for post-incident investigations only for workplace violence incidents involving physical assault (and not for threats of violence).

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Thank you in advance for considering my concerns and suggested changes. Please feel free to contact at beehiveabq@gmail.com with any questions, or if I can provide further information.

Sincerely,

Gerald Hamilton
Owner, Bee Hive Homes of Volcano Cliffs

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JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HOME CARE GROUP

April 7, 2023

Andrew Levinson, MPH
Director, Directorate of Standards and Guidance
Occupational Safety and Health Administration
Washington, DC

Re: OSHA-2016-0014: Comments on Occupational Safety and Health Administration (OSHA) Drafted Regulatory Text regarding the regarding the Potential Standard on Prevention of Workplace Violence in Healthcare and Social Assistance

Dear Mr. Levinson

Johns Hopkins Home Care Group, Inc. (JHHCG), a not for profit umbrella organization that manages Medicare-certified home health and residential service agencies, private duty and infusions services, and a durable medical equipment across the mid-Atlantic region, submits the following comments on the Occupational Safety and Health Administration (OSHA) drafted regulatory text in preparation for a proposed rule, OSHA-2016-0014, RIN 1218-AD08. As a very small business providing home-based care with less than 1500, JHHCG is one of the larger home-based care providers for Medicare beneficiaries in the state of Maryland. JHHCG appreciates the opportunity to comment on the proposed draft regulatory text in the hopes that OSHA can re-consider key recommendations before drafting a proposed rule. JHHCG is a key participant and leader within the National Association of Home Care and Hospice's (NAHC) Employee Safety Taskforce ("The Taskforce") and supports NAHC's recommendation to OSHA that **the drafted workplace violence standards not be applied to home healthcare organizations but rather OSHA rely on the General Duty Clause to enforce workplace safety.**

While JHHCG generally agrees that all employees should be able to report safety events in an effective manner, and that tracking and trending this information is essential to understanding safety issues and how it may solve them in the future, JHHCG believes the proposed regulatory text lacks specificity on the employer and provider types this rule would apply to, and that the rule itself is overly prescriptive on how agencies should manage and support employees through safety events. Within the healthcare industry the term "home healthcare" is generally used to described Medicare certified Home Health Agencies (HHAs). The proposed regulatory text references a number of related workflows to HHAs, such as OASIS assessments. However, HHAs are not the only healthcare providers rendering care in the home environment. DMEPOS companies, home infusion agencies, house-call physician practices, mobile integrated health providers, community health workers, private duty/home support agencies and other transportation or community-based services are not presented in the regulatory text. It is not clear whether the regulatory standards would apply to these agency types based on the language and definition of "home healthcare agencies" provided by OSHA. While JHHCG appreciates OSHA's effort to include HHAs and consider the needs of this vital section of healthcare, if this text were presented in a proposed rule, there would be immense confusion in the healthcare and community service industry and large differences in safety standards between various provider types. **JHHCG recommends that OSHA reconsider the scope of the regulatory text and take necessary time to understand the various home-based provider types and how this text should be applied.**

Employee safety is of critical importance to JHHCG and its ability to serve the patients in its communities. JHHCG has made a firm commitment to improve safety for its employees and has taken numerous steps to do so. This past year, leaders of JHHCG held listening sessions with a variety of staff regarding safety events that have happened while in the field, as well as their ongoing and future safety concerns. As a result of this, JHHCG, in collaboration with NAHC, created the Task Force. The Task Force has recently developed draft recommendations for organizations providing care in the home. Throughout April, the Task Force will be soliciting feedback from other home-based care organizations, to better understand how safety threats may vary and identify reasonable approaches that may be evidence-based and cost-effective. Moreover, JHHCG's President, Mary Myers participated in the Small Business Advocacy Review (SBAR) Panel and provided OSHA direct feedback regarding the proposed regulatory text. Myers noted of particular concern the following: 1. The prescriptive nature of "one size fits all" relating to the emergency communication devises which would be operationally burdensome and financially prohibitive 2. The extensive and time-consuming hazard assessment prior to the first visit 3. The requirement of a three-year look back of events, which would be very subjective and questionably relevant, 4. The mandate of the year-long post incident medical treatment.

Additionally, JHHCG has made investments into technical workflow improvements in its electronic medical record to improve communication across disciplines and teams in the organization, developed and deployed training for field employees, and is dedicating support to positions in the organization to advance workplace safety efforts. These investments and the work involved have been complex, challenging, and have added financial hardships. JHHCG is able to perform these tasks given it is a member of an integrated academic health system that has enhanced resources and institutional expertise to conduct these efforts. JHHCG is concerned given the difficulty it has experienced that the home health industry is woefully under-resourced to adopt the proposed regulatory text standards. OSHA's one size fits all approach largely ignores the uncontrolled environment that agencies delivering care in the home and community face, as well as the corresponding unique logistics and management that support the care. **JHHCG recommends that OSHA not apply the drafted workplace violence standards to home health care agencies and instead review the findings of the Taskforce to develop flexible, evidence-based standards that promote safety across all home-based provider types.**

JHHCG appreciates OSHA's commitment to employee safety and the considerations it has taken for the uncontrolled home environment of care. JHHCG recommends that home health agencies are not included in the proposed rule until further research has been completed in order to understand home based provider types and the data around feasible work place violence solutions. JHHCG suggests OSHA emulate other approaches to safety and harm prevention, and invest in research that can demonstrate evidence-based solutions. Outstanding work conducted on medication safety and harm reduction could lend as examples on how these problems can be addressed and further solutions developed. JHHCG is committed to finding and testing solutions to employee safety and invites OSHA leadership to visit and join its team on home visits in order to experience the wide breath of home-based services that exist in the industry. If there is interest in seeing this first-hand, please contact Ali Byro, Administrative Director by phone (410-288-8003) or email (abyro1@jhmi.edu). Again, we thank you for the opportunity to provide comments and for considering the feedback from stakeholders in the proposed regulatory text.

Thank You,

Mary G. Myers
President/CEO
Johns Hopkins Home Care Group

Appendix D: Workplace Violence Prevention Preliminary Initial Regulatory Flexibility Analysis (PIRFA) and Issues Document Sent to the SERs

U.S. Department of Labor

Occupational Safety and Health Administration
Washington, D.C. 20210

February 14, 2023

Dear Small Entity Representative:

Thank you for agreeing to participate as a Small Entity Representative (SER), part of the Small Business Advocacy Review (SBAR) Panel process, to examine the Occupational Safety and Health Administration's (OSHA) possible Workplace Violence Prevention standard. I am the Chair of this SBAR Panel, which is composed of government officials from OSHA, the Office of Advocacy within the U.S. Small Business Administration (SBA Office of Advocacy), and the Office of Information and Regulatory Affairs (OIRA) in the Office of Management and Budget (OMB). We very much appreciate your willingness to take the time to help us in this important work.

This SBAR Panel is being formed in accordance with the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA). Congress enacted this portion of SBREFA to ensure that small businesses potentially affected by an OSHA standard have the opportunity to provide input on OSHA's proposed rules before they are published in the Federal Register for public comment. We would like you, as a SER, to provide comments and recommendations on the potential Workplace Violence Prevention standard that OSHA is considering, including comments on the potential impacts of the elements of the draft standard on your community or business.

Enclosed are several documents for your review. There is the SER Issues Document, that provides an overview of the potential standard, the alternatives that are under consideration, and questions the Panel is particularly interested in receiving your input on. However, the Panel welcomes comment on any aspect of this potential rulemaking. Then, there is the longer and more in depth Preliminary Initial Regulatory Flexibility Analysis (PIRFA) document that further explains the draft standard and provides cost information. A complete list of enclosed materials is provided at the end of this letter; the materials have also been placed in the public docket of this rulemaking (Docket No. OSHA-2016-0014, available at the Federal eRulemaking portal via the following link: https://www.regulations.gov/docket?D=OSHA-2016-0014). You are free to share these materials with other individuals and organizations, or you may direct them to the Federal eRulemaking portal to view and download the materials.

About a month after this letter is mailed, each SER will have the opportunity to provide comments to the SBAR Panel during a videoconference. The SBAR Panel will schedule several videoconferences. Each videoconference will be open to the public for listening, but only the SERs and the members of the SBAR Panel will be permitted to participate in the discussion. We will notify you shortly of the exact date and time of your videoconference. Following the videoconference, you will have an opportunity to provide written comments if you wish. The SBAR Panel will prepare a report, based on your and the other SERs' comments, to present to the Assistant Secretary of Labor for Occupational Safety and Health or their designated acting

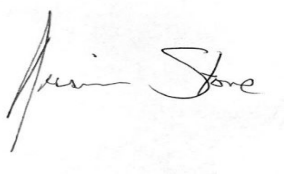
official. The report, including your written comments, will then become part of the public record of this rulemaking.

In order to include the substance of your written comments in the SBAR Panel's report, we request that you provide them within two weeks after the teleconference call (or earlier, if possible). This deadline is necessary so that the Panel can complete its report within the time limits specified by SBREFA. Your written comments may address any of the issues or concerns you have with the draft standard or any of the materials provided. Your written comments can be sent by email to Anissa Harmon at harmon.anissa@dol.gov or by fax to (202) 693-1678. Ms. Harmon is organizing much of the work of the SBAR Panel, including the teleconference calls, so please direct any administrative questions to her at (202) 693-1713. She can also assure that any technical questions you may have are directed to the correct person.

Please feel free to telephone or email us before the teleconference calls with any questions regarding this process or the enclosed materials. You may also contact Bruce Lundegren from the SBA's Office of Advocacy, whose office represents the views of small business in the SBREFA process. Mr. Lundegren's telephone number is (202) 205-6144 and his email address is Bruce.Lundegren@sba.gov. At OSHA, you may contact Ms. Harmon at the above phone number or email address, or me at (202) 693-1847 (email address, stone.jessica@dol.gov).

Thank you again for agreeing to participate in this important review. We appreciate your efforts and look forward to working with you.

Sincerely yours,



Jessica Stone, Chair
Small Business Advocacy Review Panel

Enclosure(s):

Tab 1 List of SERs and participants from OSHA, Advocacy, and OIRA
Tab 2 SER Issues Document
Tab 3 Preliminary Initial Regulatory Flexibility Analysis

cc: Bruce Lundegren, SBA Office of Advocacy
Josh Brammer, OMB OIRA

OSHA SBREFA on the Potential Standard on Prevention of Workplace Violence in Healthcare and Social Assistance
List of Small Entity Representatives - preliminary

SER Name	Organization
Bradley Coolidge	Arnot Health - Saint Joseph's Hospital
Maggie Sumioka	Asana Recovery
Luis Collado	Baptist Health South Florida
Scott Normandin	Baptist Health System
Mary Jackson	Baptist Retirement Community
Gerald Hamilton	Beehive Homes of Volcano Cliffs
Ryan Pirtle	BJC HEALTHCARE
Amanda Scott	Children's Hospital, Philadelphia
Michael Bomberger	Community Healthcare System - NE Kansas
Tana White and Doug Jones	Confluence Health
Dave Denniston	Cortlandville Fire Department
Peggy Connorton	Covenant Health
Y'vonne McGhee, Jeff Coffey, and Alex Simpson	Covenant House - Michigan
Steven Kroll	Delmar-Bethlehem EMS
Anne Weaver	Fairbanks Community Food Bank
Mike Hamel	Hoag Memorial Hospital Presbyterian
Renita Williams Thomas	In Loving Arms Healthcare for Kids
Debra Abromaitis	John Dempsey Hospital/UCONN Health
Dan Selby	Knox Community Hospital
Kristi Safranek	Lawrence County Memorial Hospital
John D'Eramo	MCCA, Inc.
Eric Clay and Denis Hyams	Memorial Hermann Southwest
Reier Thompson and Michael Hatten	Missouri Slope
Jared Shapiro	Montefiore Health System
Phillip Gregg	Ohio Health
Bobbi Jo Hurst	Orthopedic Associates of Lancaster
Craig Crosby	Phoenix Children's Hospital
Pam Clingerman	Prisma Health–Upstate
Lisa Landry	Redington-Fairview General Hospital

Chief Dave Deskis	**Thompsonville Fire Department**
Marcy McNeal	**Sunrise Hill Care Center**
Jeremy Klemanski	**The Gateway Foundation**
Ann Reifenberger	**The Legacy at St. Josephs**
Susan Fleming	**Third Avenue Charitable Organization (TACO) - San Diego**
Laura Farrell	**Trinity Community at Beaver Creek**
Marcy Kuhnhenn	**Trinity Health First Response**
Aaron Stapleton	**Trinity In-Home Care**
Mark Sevilla and Amy Woznyk	**Yale New Haven Health**

Small Business Advocacy Review Panel Members and Staff Representatives for the Potential Standard on Prevention of Workplace Violence in Healthcare and Social Assistance

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Rachel Carse	OSHA
Carl Lundgren	OSHA
Grace Shin	OSHA
Britni Wilcher	OSHA
William Baughman	OSHA
Annette Iannucci	OSHA
Rachel Michel	OSHA
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Prevention of Workplace Violence in Healthcare and Social Assistance

Issues Document

Small Business Advocacy Review Panel
February 2023

This document contains a brief discussion of select provisions that OSHA is considering in a draft rule as well as initial unit cost estimates of compliance. This document also presents potential regulatory alternatives and additional questions for SERs.

This **Issues Document** intends to serve as both a summary of the longer Preliminary Initial Regulatory Flexibility Analysis (PIRFA) and discussion guide for SERs participating in SBAR Panel teleconferences.

OSHA enumerates the rationale and considerations associated with regulatory alternatives and regulatory options in greater detail within Section VII (p. 213) of the full-PIRFA package.

In the interest of providing a more easily-referenced discussion guide for SERs during the SBREFA process, OSHA has abridged the more extensive discussions of multiple sections of the full-PIRFA in this **Issues Document**.

Table of Contents

1. Background

OSHA is considering a new standard to protect healthcare and social assistance workers from workplace violence (WPV). This draft regulatory framework, called Prevention of Workplace Violence in Healthcare and Social Assistance, would cover employers in healthcare and social assistance sectors whose employees face a heightened risk of WPV. The regulatory framework would help ensure that covered employers take necessary steps to protect workers from WPV and are appropriately prepared for emergency incidents.

OSHA convened a Small Business Advocacy Review (SBAR) Panel under the Small Business Regulatory Enforcement Fairness Act (SBREFA). The SBAR Panel has several purposes. First, it provides an opportunity for affected small employers, the Small Business Administration's (SBA) Office of Advocacy, and the Office of Information and Regulatory Affairs (OIRA) to provide OSHA with comments in advance of formal rulemaking. Second, Small Entity Representatives (SERs) and the Panel can offer OSHA recommendations about how to tailor the rule to make it cost-effective and less burdensome for affected small entities based on their review of the proposed provisions and impact estimates of the WPV Prevention draft regulatory framework. Third, early comments facilitate identification of regulatory alternatives the agency might consider. Finally, the SBAR Panel report can provide specific recommendations for OSHA to consider on issues such as reporting requirements, timetables of compliance, and whether some groups—including small entities—should be exempt from all or part of any proposed rule.

This Issues Document contains a brief discussion of topics OSHA is considering including in a proposed rule and initial unit cost estimates of provision compliance. This document also presents potential regulatory alternatives[1] as well as questions for SERs. This Issues Document is meant to serve as both a summary of the longer Preliminary Initial Regulatory Flexibility Analysis (PIRFA) and discussion guide for SERs participating in SBAR Panel teleconferences.

OSHA provides a more detailed explanation of regulatory alternatives and options in Section VII (beginning on p. 213) of the PIRFA. This Issues Document does not include discussions of wage

[1] This includes both regulatory alternatives that reduce burdens on small entities and are considered significant alternatives under the Regulatory Flexibility Act (RFA) and those that may increase burdens (also referred to as options).

rates or detailed calculations of total cost. The estimated dollar cost of a purchase is presented for costs incurred to purchase a good or service and the estimated labor resource demands where costs are accounted for in additional time necessary to comply with a requirement. The full calculations of costs, tables, and references are found in the PIRFA.

OSHA welcomes comment on all aspects of the PIRFA, but this document focuses on areas of specific interest to the agency. Throughout this document, the Panel presents specific issues and questions but SERs should feel free to raise any issues for the Panel to consider.

Reasons Why Action is Being Considered by OSHA

This draft regulatory framework is based on many years of agency research, interagency engagement, and trends in workplace violence incidents as observed through OSHA enforcement of the General Duty Clause. The Healthcare and Social Assistance sector (NAICS 62) is comprised of 20.9 million employees and is a major component of the U.S. economy. These workers face an increased risk of workplace violence resulting primarily from violent behavior of their patients, clients, residents, and/or visitors in their workplaces.

In 2019, the rate of intentional nonfatal workplace violence incidents that required the worker to take time off was significantly higher in healthcare than in private industry overall. Data from the BLS Survey of Occupational Injuries and Illnesses (SOII) for 2019 show that the average rate of workplace violence incidents for all industries is estimated at a lost-workday incidence rate of 2.0 per 10,000 employees per year. However, healthcare and social assistance sectors account for such a large segment of the U.S. workforce, and has such a high rate of workplace violence, that when you remove these sectors from the all-industry average, that 2.0 falls to 0.6 per 10,000 employees per year.

By comparison, healthcare and social assistance workers experienced a rate of violence nearly six times that, with workplace-violence-related injuries at an estimated lost-workday incidence rate of 11.7 per 10,000 full-time workers per year (9.7 intentional injury by another person and 2.0 unintentional injury while restraining or subduing)– with a total of 16,450 nonfatal injuries in 2019 alone. For certain segments of the healthcare and social assistance industry, the injury rate is even higher, such as in psychiatric and substance abuse hospitals, which had 146.5 injuries per 10,000 full-time workers per year (107.5 intentional injury by another person and 39.0 unintentional injury while restraining or subduing), and residential intellectual and developmental disability, mental health, and substance abuse facilities, which had 55.6 injuries per 10,000 full-time workers per year (44.4 intentional injury by another person and 11.2 unintentional injury while restraining or subduing) (BLS, 2019, R-4, R-8, and Special Run for Intentional vs. Unintentional 2019-2020).

Figure-1 displays the annual number and rate of WPV injuries for the industry sectors in OSHA's contemplated scope as reported by BLS Tables R-4 and R-8 for 2019. Note that these

injuries can be significant and often require many days away from work -- ranging from 1 to 180 days. The average of the median number of days away from work for each injury is 14 days. (BLS Special Run Data - Number, median days away from work and relative standard errors of occupational injuries and illnesses involving days away from work 3 in health care and social assistance from violence by industry, occupation, and source for All United States, 2019)

Figure-1
Annual Number and Rate of WPV Injuries for Industry Sectors in the Contemplated Scope, [2019]

Sector	NAICS	Industry	Injuries	Rate per 10,000 FTE
General hospitals, incl. emergency departments	622000	Hospitals	7,160	17.8
Behavioral Health	622200	Psychiatric and substance abuse hospitals	1,600	152
	623200	Residential behavioral health facilities	3,120	58.2
	621112	Offices of Physicians, Mental Health Specialists	130	26.6
Residential care facilities	623100	Nursing care facilities	780	19.1
	623300	Continuing care retirement communities and assisted living facilities for the elderly	3,280	14.4
Home healthcare	621600	Home healthcare	520	6.1
Emergency medical services	621910	Ambulance Services	260	18.6
Social assistance services	624100	Individual and Family Services	300	20.5
	624200	Community Food and Housing, and Emergency and Other Relief Services	140	8.9
	624300	Vocational Rehabilitation Services	530	21.8

Source: BLS, Tables R4, R8 (2019)

The literature on workplace violence includes a number of surveys of healthcare and social assistance workers, which are useful for understanding the prevalence of workplace violence. Surveys of healthcare and social assistance workers are especially useful in accurately characterizing the extent of the workplace violence risk, particularly because the issue of underreporting of workplace violence incidents in healthcare and social assistance sectors seems to be quite prevalent in these industries.

Key Requirements in the Draft Standard

OSHA's draft regulatory framework addresses, and aims to reduce, the prevalence and the severity of workplace violence in health care and social assistance settings. For the purpose of this potential standard, OSHA focuses solely on type II workplace violence, which are violent acts committed by patients, clients, and their visitors upon workers within a healthcare or social

assistance setting. OSHA is defining "workplace violence incident" as any violent act (including physical assault and threat of physical assault) directed toward persons at work or on duty by patients, clients, or their visitors.

OSHA's draft regulatory framework lays out a programmatic, performance-based approach to addressing WPV that OSHA believes would allow employers to tailor the program to their workplace to address the hazards present in their particular facility. For example, this programmatic approach would allow for lower training requirements for some categories of employees and flexibility in the engineering and administrative controls for establishments based on the characteristics of the facility and the rates of WPV.

The key requirements of the standard are summarized below – but are also expanded upon further on in this document to introduce various regulatory alternatives or options, and are also explained in much greater detail in Section IV of the full PIRFA document. The major elements of the standard include:

(1) A workplace violence prevention program (WVPP) - employers would be required to develop (with the involvement of employees) and implement a written WVPP. The WVPP would focus on developing processes and procedures appropriate and specific for the size and complexity of the specific establishment's operation or work setting. OSHA feels that a written plan is necessary to allow employees working on all shifts to refer to procedures that must be followed for optimal prevention and response to incidents of workplace violence.

Such procedures, under OSHA's draft regulatory framework, would include for example, how an employee can report a violent incident, threat, or other workplace violence concern; how employee concerns will be investigated; and how employers would develop procedures to communicate and coordinate their WVPP with other employers at the same worksite. The WVPP would also outline requirements for employers to develop procedures for involving non-managerial employees and their representatives (if necessary) in developing and implementing the WVPP. OSHA would also require that covered employers *reevaluate* policies and procedures on a regular basis to identify deficiencies and take corrective action.

(2) Hazard assessments - Employers would be required to perform regular hazard assessments based on their own injury records and identify and mitigate hazards. These employer evaluations are intended to identify environmental and organizational risk factors that may occur throughout a fixed establishment site. Under the draft regulation, employers would have the flexibility to determine the best approach to accomplish the overall hazard assessment. In addition, each hazard assessment could be tailored to specialized clinical services, the physical characteristics of the establishment, the number of patients and clients in the establishment, and characteristics of the surrounding community of the establishment.

The employer would evaluate, at a minimum, all data recorded in the violent incident log and incident investigations and data from all other available sources, including surveys of employees; OSHA 300 logs; Workers' Compensation claims; insurance loss information; and other ward-specific incident logs. Employers would also assess for establishment characteristics such as locations without sufficient emergency communication capabilities; Ineffective communication mechanisms or practices regarding patient/client/resident status between shifts and between personnel; adequate employee staffing patterns; entryways where unauthorized entrance may occur; and more.

(3) Implementation of Control Measures - Employers would be required to implement controls to mitigate the hazards found during the hazard assessment. For example, placement of curved mirrors at hallway intersections or concealed areas deemed to be a hazard, provision of a lockable 'safe room' for employees during emergencies, keyless door systems where public access to employee areas are deemed problematic, etc.

OSHA understands that employers who provide services within patients' and clients' private residences, or in other field-based settings, as with home healthcare, home or field-based social assistance, and emergency medical services may have very little control over their employees' working environments. In the draft regulatory text, OSHA has provided Table E-1 titled "Home Healthcare and Field -Based Social Assistance Services – Workplace Assessment and Control Measures" ("Table E-1"). This table provides draft assessment and control requirements for employers within the home healthcare and field-based social assistance sectors.

The draft regulatory text also includes Table E-2 "Emergency Medical Services –Workplace Assessment and Control Measures". EMS employees face many types of hazards, including workplace violence. This table provides the draft assessment and control methods for employers within emergency medical services.

High-Risk Service Areas - Consistent with the programmatic nature of this draft regulatory framework, in certain establishments, or specific units of an establishment, wherein incidents of workplace violence are a problem, as evidenced by their frequency of occurrence, in the draft regulatory framework, OSHA has defined a high-risk service area as "An area where a workplace violence incident has occurred in the previous three years". OSHA (and employers) would therefore consider any such units that experienced WPV incidents in previous three years to be "high-risk", and this would kick in an added tier of control requirements (e.g., specifications for alarm systems added response procedures, etc.), as well as more stringent training requirements (e.g. inclusive of more advanced simulations and drills involving de-escalation, restraint policies, and seclusion procedures, if applicable.)

(4) Training - OSHA is considering specific training requirements for employees and their supervisors. Education and training are key elements of a workplace violence prevention program and help to ensure that all staff members are aware of potential hazards and how to protect themselves and their coworkers through established policies and procedures. Training

raises the overall safety and health knowledge across the workforce and provide employees with the tools necessary to identify workplace safety and security hazards. Training also helps to address potential problems before they arise and can ultimately reduce the likelihood of workers being assaulted.

Training requirements might include different tiers (in terms of training content and time in training) for employees who, for example, have occasional contact with patients (e.g., environmental services, engineering services, laundry services, meal delivery, information technology, and others), for employees who provide direct patient care (e.g., nurses, physicians, nursing assistants, patient care assistants, technicians, and other healthcare workers, social assistance workers, as well as employees providing emergency medical services); any employees who might be expected to respond to workplace violence incidents, and general awareness requirements for all other employees not described above.

(5) Incident investigation and maintenance of a workplace violence log – Employers would need to maintain a specific workplace violence recordkeeping log and perform incident investigation procedures. Post-incident investigation is an important component of an effective violence prevention program, and the information obtained from these investigations can inform other elements of the employer's WVPP. Investigating incidents of workplace violence thoroughly can provide insight into steps that can be taken to avoid future workplace violence incidents and associated injuries.

OSHA would also require employers to document the significant contributing factors, recommendations, and corrective measures taken for each investigation of WPV incidents in a specific workplace violence incident log, regardless of whether the incident meets the criteria for an OSHA recordable injury or illness under 29 CFR Part 1904 Recordkeeping and Reporting Occupational Injuries and Illnesses. In other words, this log is completely separate from the recordkeeping requirements of 29 CFR Part 1904.

(6) Anti-retaliation policy to encourage employee reporting of workplace violence incidents – OSHA also contemplates a requirement for employers to inform each employee that employees would have a right to the protections required by any eventual rule, and that employers would be prohibited from discharging or in any manner discriminating against any employee for exercising their right to the protections required by such a rule, or for engaging in actions that are required a rule.

Potential Costs of the Draft Standard

In the PIRFA, OSHA presents the draft regulatory framework's total cost by NAICS code and healthcare setting (see Table 39 in the PIRFA). These costs represent the compliance burden across all draft provisions of the rule and all affected facilities. As shown in Exhibit 1, OSHA

estimates the total cost to be $1.22 billion per year (at a three percent discount rate) or $4,047 per establishment for the 300,447 affected establishments.

Exhibit 1. Total Annualized Costs of the Workplace Violence Prevention Regulatory Framework, by Rule Section ($2019)

Draft Rule Section	Total Annualized Cost, millions, $2019, 3% discount rate
Part C – Workplace Violence Prevention Plan	$65.1
Part D – Workplace Hazard Assessment	$63.6
Part E – Controls	$104.8
Part F – Training	$908.8
Part G – Violent Incident Reporting	$73.5
Total	$1,215.9

Source: OSHA, 2021.
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

2. Scope, Affected Entities, and Other Industry Characteristics

Scope

The draft regulatory framework for the Prevention of WPV in Healthcare and Social Assistance applies to all employers with employees that work in the sectors listed below.

- **Hospitals, including emergency departments.** This refers to general medical, surgical, and specialty hospitals primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with any of a wide variety of medical conditions.
- **Behavioral healthcare facilities**, including (1) psychiatric hospitals and residential behavioral health facilities, and (2) ambulatory mental health care and ambulatory substance abuse treatment centers.
- **Residential care facilities** that provide residential care combined with nursing, supervisory, or other types of assistance as required by the residents.[1] These include establishments providing inpatient nursing and rehabilitative services, where care is generally provided for an extended period;
- **Home healthcare**, including field-based social assistance. This includes any care or services provided at the patient/client's residence;
- **Social assistance**, where social assistance services are directly provided. This excludes child day care centers; and
- **Emergency medical services**, including paramedics, emergency medical technicians (EMTs), and firefighters cross-trained and performing services as paramedics or EMTs.

[1] Note that Residential Intellectual and Developmental Disability Facilities and Residential Mental Health and Substance Abuse Facilities are both included in the scope of the behavioral health care facility setting, rather than the residential care facility setting.

Coverage of State and Local Government Employees

State- and local-government entities are specifically excluded from coverage under the OSH Act Workers employed by these entities only have OSH Act protections if they work in states that have an OSHA-approved State Plan. The following states and territories have OSHA-approved State Plans, and therefore state- and local-government employers providing healthcare and social assistance services in these states are included in OSHA's analysis for SBREFA:

Alaska	Indiana	Massachusetts	New York	Tennessee
Arizona	Iowa	Michigan	Nevada	Utah
California	Kentucky	Minnesota	North Carolina	Vermont
Connecticut	Maine	New Jersey	Oregon	Virginia
Hawaii	Maryland	New Mexico	Puerto Rico	Washington
Illinois			South Carolina	Wyoming

OSHA preliminarily estimates that approximately 12.9 million employees in 288,700 establishments in the private sector and 1.1 million employees in 11,750 public agencies (state and local government) are exposed to the risk of workplace violence and would be affected by the draft standard.

ISSUES

- OSHA has selected the sectors listed in the scope because OSHA's experience, BLS data, and the best available epidemiological literature consistently demonstrate that these sectors have the highest potential risk for WPV. OSHA welcomes feedback from the SERs on the draft scope of the standard.
- Is it appropriate to include all employers that are currently identified as within the scope of this draft standard? Why or why not?
- Should any types of employers or entities currently included in the scope of this draft standard be excluded? If so, please specify the type of employer or entity, and explain why.
- Has OSHA overlooked any sectors or service providers that would be included as defined by the scope in the regulatory framework but whose unique workplace violence risk factors have not been accurately or fully recognized in the PIRFA. Or are there sectors or service providers that should be included but are not? If so, please identify them and give the reasons why they would or should be included.

Affected Entities

Table 1 summarizes the entities covered by the draft regulatory framework. "Entities" include private firms, nonprofits, and government organizations. By contrast, an "establishment" is a single physical workplace. An entity may have multiple establishments, and might, for example, be a parent healthcare or social assistance provider system that operates multiple establishments either regionally or nationwide. OSHA estimates that approximately 201,700 entities would be subject to a WPV rule, including approximately 300,400 establishments and 14 million employees.

Table 1. Summary of Potentially Regulated Entities

Healthcare Setting*	Behavioral Health Facilities	Hospitals, other than mental health	Residential Care Facilities	Home Healthcare Services	Social Assistance	Emergency Responders	Total
For-profit							
Entities	41,202	4,777	24,289	39,132	9,828	2,332	121,561
Establishments	58,344	8,754	37,589	52,714	13,744	4,187	175,332
Employees	597,823	948,597	1,957,969	1,980,102	119,947	157,703	5,762,141
Non-Profit							
Entities	11,460	1,995	6,254	11,931	35,755	995	68,391
Establishments	32,549	4,187	9,845	15,432	49,568	1,787	113,368
Employees	748,537	3,902,235	760,479	652,066	990,072	43,441	7,096,830
State and Local Government							
Entities	2,007	925	697	510	1,799	5,808	11,747
Establishments	2,007	925	697	510	1,799	5,808	11,747
Employees	137,072	528,797	44,190	27,281	91,213	265,303	1,093,856
Total							
Entities	54,670	7,697	31,240	51,573	47,382	9,136	201,698
Establishments	92,900	13,866	48,131	68,656	65,111	11,782	300,447
Employees	1,483,432	5,379,629	2,762,638	2,659,449	1,201,232	466,447	13,952,827

Source: OSHA, 2023, based on County Business Patterns (CBP) (2019a and 2019b), BLS (2018), USFA (2018).
* The Regulatory Flexibility Act (RFA) defines small governmental jurisdictions (sometimes referred to as "small governments" in this analysis) as those that serve a population of less than 50,000. For government organizations, local-government entities that are located in counties with population under 50,000 are the basis for estimating RFA-defined small governments. For analytical convenience, in the PIRFA the estimated number of affected state and local government entities and establishments are identical. OSHA requests comment from SERs on this analytical assumption.
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

Potentially Regulated Small Entities

The PIRFA presents costs and impacts for the affected entities based on *size*:

> **All in-scope entities; small entities, as defined by U.S. Small Business Administration (SBA) size standards in accordance with the Regulatory Flexibility Act (RFA) as amended by the Small Business Regulatory**

Enforcement Fairness Act (SBREFA); and very small entities, defined as entities having fewer than 20 employees.

The SBA's Table of Small Business Size Standards defines small business thresholds for each NAICS industry. These thresholds are entity-level and, for private firms, depend on the industry and for in-scope private firms, the SBA small business thresholds are revenue-based, ranging from $8.0 to $41.5 million in revenue per year depending on the NAICS industry. Table 3 in the PIRFA presents SBA-defined small entity/business thresholds for potentially affected NAICS industries.

The RFA defines small non-profit organizations as those that are not dominant in their field, and small governmental jurisdictions (sometimes referred to as "small governments" in this analysis) as those that serve a population of less than 50,000. For purposes of SBREFA, OSHA considers all nonprofits as fitting the RFA definition of small nonprofits. For government organizations, small governments are those that serve populations of under 50,000.[2]

OSHA's estimates for very small entities (those with fewer than 20 employees) were derived from 2017 CBP data, as described in the PIRFA at Appendix A.

Table 2 presents, for each healthcare setting, the number of entities, establishments, and employees by size category: all sizes, SBA/RFA-defined small entities, and very small entities (defined as those with fewer than 20 employees). OSHA preliminarily estimates that approximately 186,000 small entities, employing about 10 million employees may be affected by this potential rule. Of these SBA/RFA-defined small entities, 128,000 are very small entities employing fewer than 20 people. Nearly 572,000 employees work for very small entities covered by this potential rule.

Table 2. In-Scope Total, Small, and Very Small Entities

Healthcare Setting	All Sizes	SBA/RFA-Defined Small	Very Small
Entities			
Behavioral Health Facilities	54,670	52,174	42,934
Hospitals, other than mental health	7,697	6,277	2,746
Residential Care Facilities	31,240	29,434	15,897
Home Healthcare Services	51,573	50,020	32,108

[2] Even though OSHA considers all nonprofits, regardless of revenue size, to be small entities according to the RFA definition, OSHA also keeps track of which non-profit entities meet the revenue criteria applied to for-profit entities so that entities are differentiated by the size of their operation (versus RFA designation) for the purposes of costing. Many cost inputs in the analysis are a function of facility size, so OSHA wants to maintain this characterization of non-profit entities for the cost analysis.

Table 2. In-Scope Total, Small, and Very Small Entities

Healthcare Setting	All Sizes	SBA/RFA-Defined Small	Very Small
Social Assistance Facilities	47,382	45,614	33,460
Emergency Responders	9,136	8,497	2,643
Total	201,698	192,016	129,788
Establishments			
Behavioral Health Facilities	92,900	81,576	43,389
Hospitals, other than mental health	13,866	8,743	2,766
Residential Care Facilities	48,131	35,367	16,235
Home Healthcare Services	68,656	57,684	32,245
Social Assistance Facilities	65,111	61,841	34,267
Emergency Responders	11,782	9,794	2,678
Total	300,447	255,005	131,580
Employees			
Behavioral Health Facilities	1,483,432	1,106,995	129,301
Hospitals, other than mental health	5,379,629	4,068,452	18,897
Residential Care Facilities	2,762,638	1,700,716	86,876
Home Healthcare Services	2,659,449	1,744,657	151,505
Social Assistance Facilities	1,201,232	1,077,556	159,861
Emergency Responders	466,447	282,999	25,409
Total	13,952,827	9,981,375	571,849

Source: OSHA, 2023, based on CBP (2019a and 2019b), SBA (2019).
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

Direct Patient/Client/Resident Care and Contact Employees

The regulatory framework distinguishes between general employees covered by the draft framework (e.g., all employees who may work in a covered establishment) and those employees who may be at greater risk, for whom employers would be required to provide specific training on prevention of WPV. The draft framework requires training for each worker who provides direct patient/client/resident care, has direct patient/client/resident contact, or has WPV incident response duties, and their supervisory staff. OSHA's draft regulatory framework also includes the following definitions:

> **Direct patient/client/resident care** means job duties that involve the delivery of healthcare services or social assistance services with hands-on or face-to-face contact with patients or clients. Workers

who provide direct patient/client/resident care include nurses, physicians, technicians, home care workers visiting client homes, as well as workers providing emergency medical services.

Direct patient/client/resident contact means job duties where workers perform support work that requires them to be in patient/client/resident care areas. Such work includes housekeeping, maintenance, meal delivery, security, and information technology.

To estimate the number of patient/client/resident care and contact (PCRCC[3]) employees for each healthcare setting, OSHA used the BLS' most recent Occupational Employment and Wage Statistics (OEWS) dataset which provides NAICS-specific estimates of employment *by occupation*. Within the Healthcare and Social Assistance sector, OES includes 485 unique occupations, including both healthcare and non-healthcare occupations. Of these, OSHA has identified 80 occupations that fit within the definition of direct patient/client/resident care (e.g., nurses, physicians, nursing assistants, patient client care assistants, technicians, and other healthcare workers, social workers visiting client homes, as well as employees providing emergency medical services, and others), 10 occupations with direct patient/client/resident contact (but not care) (e.g., environmental services, engineering services, laundry services, meal delivery, information technology staff, and others), and 10 occupations of associated supervisory staff. The list of occupations is included in Appendix B of the PIRFA. OSHA also calculated the proportion of employees in these categories for each NAICS code. OSHA assumes that all employees in facilities with five or fewer total employees function as PCCRC employees.

Table 3 presents the resulting estimates of the number of direct PCCRC employees by healthcare setting. OSHA estimates that approximately 10.4 million in-scope employees work in direct PCCRC occupations. Approximately 3.8 million PCCRC employees work in SBA-defined small entities and about 487,000 PCCRC employees are in very small entities.

[3] These employees are also given the title "direct patient/client/resident care and contact employees" in the PIRFA. The two terms are used interchangeably.

Table 3. Employees in Direct Patient/Client/Resident Care or Contact (PCCRC) Occupations

Setting and Ownership	Percent of Employees in Care or Contact Occupations	Direct Care Occupation Employees	Direct Contact Occupation Employees	Total Direct Care or Contact Occupation Employees	Total Direct Care or Contact Employees in SBA/RFA-Defined Small Entities	Total Direct Care or Contact Employees in Very Small Entities
Behavioral Health Facilities	74%	1,089,039	76,732	1,165,771	607,323	113,405
Hospitals, other than mental health	67%	3,356,951	276,339	3,633,291	239,493	12,097
Residential Care Facilities	78%	1,756,197	403,694	2,159,892	1,035,269	66,345
Home Healthcare Services	86%	2,269,836	20,688	2,290,524	1,271,399	142,468
Social Assistance Facilities	66%	710,122	61,173	771,295	506,040	132,775
Emergency Responders	79%	363,801	345	364,147	205,514	19,890
	Total	9,545,947	838,972	10,384,919	3,865,038	486,980

Source: OSHA, 2023, based on BLS (2019).
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

For each NAICS industry, OSHA estimated the proportion of employees in patient/client/resident care and patient/client/resident contact occupations, including their supervisors, and applied these industry-level proportions to estimates of employment. This resulted in estimates of the number of employees, by industry, in these specific occupations.

Table 4 presents the estimated number of PCCRC employees per establishment for each ownership category: for-profit, non-profit, state government, and local government establishments, respectively. These data are key inputs for the analyses of unit costs for provisions in the draft regulatory framework affecting PCCRC employees.

Table 4a. Number of Direct Patient/Client/Resident Care or Contact Employees per Facility

NAICS	NAICS Description	Direct Patient/Client/Resident Care/Contact Employees per Facility		
		Large	SBA/RFA-Defined Small	Very Small
For-Profit Facilities				
621112	Offices of Physicians, Mental Health Specialists	NA	3	2
621330	Offices of Mental Health Practitioners (except Physicians)	NA	4	2
621420	Outpatient Mental Health and Substance Abuse Centers	15	9	4
621493	Freestanding Ambulatory Surgical and Emergency Centers	18	10	5
621610	Home Health Care Services	68	23	5
621910	Ambulance Services	41	26	6
622110	General Medical and Surgical Hospitals	522	80	3
622210	Psychiatric and Substance Abuse Hospitals	267	126	4
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	125	52	2
623110	Nursing Care Facilities (Skilled Nursing Facilities)	92	68	4
623210	Residential Intellectual and Developmental Disability Facilities	13	12	5
623220	Residential Mental Health and Substance Abuse Facilities	36	18	4
623311	Continuing Care Retirement Communities	61	29	5

Table 4a. Number of Direct Patient/Client/Resident Care or Contact Employees per Facility

NAICS	NAICS Description	Direct Patient/Client/Resident Care/Contact Employees per Facility		
		Large	SBA/RFA-Defined Small	Very Small
623312	Assisted Living Facilities for the Elderly	40	12	4
623990	Other Residential Care Facilities	15	8	5
624110	Child and Youth Services	19	8	4
624120	Services for the Elderly and Persons with Disabilities	92	23	4
624190	Other Individual and Family Services	14	4	2
624210	Community Food Services	7	4	4
624221	Temporary Shelters	NA	6	4
624229	Other Community Housing Services	NA	3	3
624230	Emergency and Other Relief Services	4	2	2
624310	Vocational Rehabilitation Services	14	7	4
	Firefighter-EMTs	350	27	11
Non-Profit Facilities				
621112	Offices of Physicians, Mental Health Specialists	NA	10	4
621330	Offices of Mental Health Practitioners (except Physicians)	NA	6	4
621420	Outpatient Mental Health and Substance Abuse Centers	33	18	4
621493	Freestanding Ambulatory Surgical and Emergency Centers	27	15	5
621610	Home Health Care Services	126	42	6
621910	Ambulance Services	26	17	8
622110	General Medical and Surgical Hospitals	1028	157	3
622210	Psychiatric and Substance Abuse Hospitals	323	152	NA
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	355	149	3
623110	Nursing Care Facilities (Skilled Nursing Facilities)	119	88	6
623210	Residential Intellectual and Developmental Disability Facilities	18	16	6
623220	Residential Mental Health and Substance Abuse Facilities	33	17	5
623311	Continuing Care Retirement Communities	207	97	7
623312	Assisted Living Facilities for the Elderly	49	15	5
623990	Other Residential Care Facilities	32	17	5
624110	Child and Youth Services	30	12	5
624120	Services for the Elderly and Persons with Disabilities	92	23	5
624190	Other Individual and Family Services	38	12	5
624210	Community Food Services	7	4	4
624221	Temporary Shelters	NA	10	4
624229	Other Community Housing Services	NA	7	3
624230	Emergency and Other Relief Services	23	4	4
624310	Vocational Rehabilitation Services	38	19	3

Source: OSHA, 2023. NA = no establishments. There are no establishments that qualify as small entities under the RFA definitions.

Table 4b. Number of Direct Patient/Client/Resident Care or Contact Employees per Facility, State Government Facilities

NAICS	NAICS Description	Patient/Client/Resident Care/Contact Employees per Facility	
		Large	Very Small
621112	Offices of Physicians, Mental Health Specialists	14	9
621330	Offices of Mental Health Practitioners (except Physicians)	NA	NA
621420	Outpatient Mental Health and Substance Abuse Centers	25	5
621493	Freestanding Ambulatory Surgical and Emergency Centers	11	4
621610	Home Health Care Services	34	5
621910	Ambulance Services	NA	NA
622110	General Medical and Surgical Hospitals	1336	5
622210	Psychiatric and Substance Abuse Hospitals	59	1
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	207	3
623110	Nursing Care Facilities (Skilled Nursing Facilities)	123	6
623210	Residential Intellectual and Developmental Disability Facilities	65	23
623220	Residential Mental Health and Substance Abuse Facilities	36	8
623311	Continuing Care Retirement Communities	98	7
623312	Assisted Living Facilities for the Elderly	7	2
623990	Other Residential Care Facilities	28	7
624110	Child and Youth Services	46	13
624120	Services for the Elderly and Persons with Disabilities	131	16
624190	Other Individual and Family Services	65	18
624210	Community Food Services	NA	NA
624221	Temporary Shelters	NA	NA
624229	Other Community Housing Services	NA	NA
624230	Emergency and Other Relief Services	NA	NA
624310	Vocational Rehabilitation Services	9	2
	Firefighter-EMTs	37	10

Source: OSHA, 2023. NA = no establishments. There are no establishments that qualify as small entities under the RFA definitions.

Table 4c. Number of Direct Patient/Client/Resident Care or Contact Employees per Facility, Local Government Facilities

NAICS	NAICS Description	Direct Patient/Client/Resident Care/Contact Employees per Facility		
		Large	SBA/RFA-Defined Small	Very Small
621112	Offices of Physicians, Mental Health Specialists	17	2	NA
621330	Offices of Mental Health Practitioners (except Physicians)	37	3	2
621420	Outpatient Mental Health and Substance Abuse Centers	86	14	5
621493	Freestanding Ambulatory Surgical and Emergency Centers	87	10	5
621610	Home Health Care Services	53	24	5
621910	Ambulance Services	28	18	6
622110	General Medical and Surgical Hospitals	580	135	3
622210	Psychiatric and Substance Abuse Hospitals	199	94	NA
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	96	NA	NA
623110	Nursing Care Facilities (Skilled Nursing Facilities)	276	71	4
623210	Residential Intellectual and Developmental Disability Facilities	40	14	5
623220	Residential Mental Health and Substance Abuse Facilities	26	17	5
623311	Continuing Care Retirement Communities	51	24	5
623312	Assisted Living Facilities for the Elderly	15	4	4
623990	Other Residential Care Facilities	38	14	4
624110	Child and Youth Services	78	11	5
624120	Services for the Elderly and Persons with Disabilities	38	23	4
624190	Other Individual and Family Services	89	10	4
624210	Community Food Services	5	3	4
624221	Temporary Shelters	NA	6	4
624229	Other Community Housing Services	7	6	3
624230	Emergency and Other Relief Services	6	4	4
624310	Vocational Rehabilitation Services	20	10	5
	Firefighter-EMTs	165	23	10

Source: OSHA, 2023. NA = no establishments. There are no establishments that qualify as small entities under the RFA definitions.

For discussion's sake OSHA estimated how injuries are distributed between patient/client resident care employees, patient/client/resident contact employees, and other employees in the healthcare in social assistance sectors. Upon review of BLS Special Run Data for Number of WPV Injuries by Occupation within healthcare and social assistance OSHA found, that, in 2019:

- Patient/Client/Resident Care Employees accounted for 78 percent of WPV injuries;

- Patient/Client/Resident Contact Employees accounted for 20 percent of WPV injuries; and
- All other occupations in healthcare and social assistance accounted for 2 percent of WPV injuries.

OSHA notes that BLS data are not broken down so neatly as to provide precise numbers to work with, but for discussion's sake during this SBREFA process, these may be reasonable estimates to work with.

ISSUES

- Do you agree with OSHA's preliminary approach that addresses both patient/client/resident care employees and patient/client/resident contact employees? Why or why not?
- Is there a different distinction OSHA should make between different types of workers? For example, are there additional divisions of workers that would better represent different levels of risk of exposure to potential WPV situations?
- Is it clear to SERs how OSHA has presented the contemplated coverage for workers who have direct patient/client/resident contact vs. workers who provide direct patient/client/resident care – as well as the rest of the workers in a covered establishment?
- OSHA welcomes any feedback on the types of employees potentially covered by a WPV Prevention standard. Are there any employees that OSHA has not considered that you think should be included? And conversely, are there any employees OSHA has included that you think should be excluded? Please explain your answer if possible.
- As an owner or operator of a healthcare or social assistance facility, are your direct patient/client/resident care (PCCRC) employees exposed to a higher risk of WPV due to their closer proximity and work with the serviced population?
- Are the per-facility estimates of PCCRC employment in Table 4 consistent with your observation for your establishment or agency and with your NAICS industry? If not, please describe how your observed employment patterns differ from those presented in Table 4.
- OSHA welcomes comment on the employment of PCCRC employees in your facility, including the trends in employee turnover (hiring and separation) that you have observed in your industry. What are external and/or internal factors that can impact PCCRC turnover?

3. Regulatory Alternatives and Options That Would Change the Scope of the Draft Standard

Table A-1 in Appendix A at the end of this document presents the costs for the regulatory alternatives and options addressing scope, as well as those for the other regulatory alternatives and options evaluated by OSHA. OSHA invites comments from SERs on the agency's preliminary estimate of the costs for regulatory alternatives.

Scope Alternative #1: **Standard applies to "patient/client/resident care" only – not "patient/client/resident contact"; Exempt patient/client/resident contact employees from scope of the rule.**

OSHA's draft regulatory framework applies protections to employees with direct patient/client/resident contact and those who provide direct patient/client/resident care. Taken together, the total cost for coverage of both sets of employees is $1.22 billion.

As an alternative, OSHA's rule could apply only to employees who provide direct patient/client/resident care. Employees who perform support work that might involve direct patient/client/resident contact (e.g., housekeeping, maintenance, meal delivery), but not direct patient/client/resident care, would not be covered under this alternative. If OSHA were to cover only direct patient/client/resident care employees, OSHA estimates that this would result in a cost reduction of $26.6 million, a 2.2 percent reduction in costs in relation to the default (baseline) cost total of $1.22 billion. OSHA also notes that patient/client/resident contact employees may account for approximately 20 percent of all WPV injuries, that would amount to over 3,000 injuries per year that would be left unaddressed.

ISSUES

- Should OSHA include both direct patient/client/resident care AND direct patient/client/resident contact employees in the scope of this potential standard for some or all provisions? Are there any scenarios where it would be appropriate to exclude some workers from some, or all, of the potential standard?
- If OSHA were to exclude patient/client/resident contact employees from the scope of the standard, would significant risk of harm from WPV remain for those non-covered workers?
- Are there circumstantial differences between employees whose work responsibilities involve direct patient, client, or resident contact versus those that provide direct patient, client, or resident care, in terms of the amount of time spent in close proximity with patients, clients, or residents? Specifically, OSHA asks about the nature of these interactions, the surroundings in which the interactions take place, or other work

differences that make it more or less likely that either group of employees (contact or care) may experience WPV?

- With specific examples, please describe in detail the types of workplaces or other conditions where the presence of controls prevented, or you believe could prevent, violent incidents involving patient/client/resident contact employees.
- Are there any other categories of workers currently covered by the regulatory framework that should be excluded? Why? Please provide specific reasons for including or excluding categories of occupational groups.

Scope Alternative #2: **Within Social Assistance sectors, limit the scope to include only NAICS 6241 - Individual and Family Services.**

Social assistance is a tremendously diverse industry sector covering a broad scope of services including Individual and Family Services (NAICS 6241), Emergency and Other Relief Services (NAICS 6242), and Vocational Rehabilitation Services (NAICS 6243). BLS data indicate elevated rates of WPV across these social assistance sectors compared with the average for general industry. For example, whereas the average rate for WPV injuries for all industries in 2019 was 2.0 per 10,000 full time equivalent (FTE) employees, the incidence rates for NAICS 6241 Individual and Family Services, NAICS 6242 Emergency and Other Relief Services, and NAICS 6243 Vocational Rehabilitation Services were, respectively, 9.1, 11.4, and 19.1. As such, OSHA seeks feedback from SERs on whether all types of establishments that operate under NAICS 624 should be covered in the scope of this potential standard, or whether the applicability of a WPV prevention standard should be more limited.

OSHA also understands that social assistance services do not always fit into such distinct categories, and that there may be considerable overlap between the NAICS industries described above, and the services that are offered to social assistance clients through social assistance establishments. OSHA notes that many social assistance workers work within other facilities covered under the scope of this draft regulatory framework (e.g., hospitals, emergency departments, psychiatric hospitals and residential behavioral health facilities, and residential care facilities) and would already be covered.

However, OSHA also believes that one sector of social assistance, NAICS 6241 Individual and Family Services, may be most closely aligned with that of the healthcare industry. NAICS 6241 includes adult day care centers (elderly, disabled, etc.), non-medical home care of the elderly, disability support groups, companion services for elderly or disabled clients, and senior citizen centers. NAICS 6241 also encompasses alcoholism and drug addiction counseling, self-help organizations, hotline centers, counseling services, crisis centers (for rape, suicide, etc.), support group services, and other individual and family social services. Additionally, NAICS 6241

includes adoption agencies, youth centers (except recreational only), foster care placement services/agencies, and child welfare services.

However, OSHA is concerned about this alternative, because the rates of violence are either similar or even higher in 6242 and 6243 than in 6241, and these workers also need protection from WPV. Exempting 6242 and 6243 would amount to approximately 670 injuries per year that would be left unaddressed.

If OSHA were to cover only NAICS 6241 Individual and Family Services employers within Social Assistance and exclude other sectors within NAICS 624, this would result in a cost reduction of $24.0 million, equivalent to a 2.0 percent change in annualized cost.

ISSUES

- OSHA seeks feedback from SERs on whether the agency should narrow the focus within the social assistance sector to NAICS 6241 and exclude other industries under NAICS 624. Or should the agency maintain a broad focus and include all industries within the social assistance sector under NAICS 624? Why or why not?
- Are there industries within the social assistance sector that OSHA has not included that should be covered? Please explain.
- Are the situations in which social assistance workers encounter WPV similar to those encountered by workers in healthcare settings? Does this vary depending on whether these are field-based social assistance services or those provided within a fixed establishment?
- Do you think it's appropriate to cover both healthcare and social assistance under one standard? Why or why not?
- Should there be different requirements for healthcare settings as opposed to social assistance settings? If so, please identify those requirements and explain your reasoning.

Scope Alternative #3: **Eliminate non-fixed location sectors from the standard (Emergency Response, Home Healthcare, and Field-Based Social Assistance Services)**

OSHA's scope in this draft regulatory framework covers a diverse range of sectors within the healthcare industry and the estimated total cost for inclusion of all these sectors is $1.22 billion. Many employers within these industries operate within a fixed facility or establishment-based institutional setting, however some of these, including Emergency Medical Services, Home Healthcare, and Field-Based Social Assistance Services, work outside of a fixed location that may be more difficult to control. Although OSHA is concerned about not covering workers in sectors that face an elevated risk of WPV, the agency recognizes that it may be harder for these

employers to comply with the draft regulatory framework. Employees in these sectors experience on the order of 2,900 injuries per year.

This alternative would eliminate coverage among employees in field-based sectors (i.e., emergency medical services, field-based healthcare, field-based social assistance). Only those employed in a fixed facility or establishment (i.e., service center, hospital) would be covered. Removal of these three sectors from the scope would result in a cost reduction of $285.4 million and a percent change of annualized cost of (-23.5%).

ISSUES

- Should OSHA remove some or all of these field-based sectors— Emergency Medical Services, Home Healthcare, and Field-Based Social Assistance Services—from the scope of the draft regulatory framework, and instead focus upon the establishment-based operations? Why or why not?
- What difficulties do employers in field-based settings face when trying to protect workers from WPV? How do they deal with these challenges? OSHA is particularly interested in challenges that may be different than those faced in facility-based settings.
- How can employers ensure that specific assessment and control elements indicated in the draft regulatory framework are implemented in remote settings?
- Do you think OSHA's approach to covering employers in field-based settings is appropriate? Why or why not? OSHA welcomes any thoughts SERs have on how to effectively improve safety in these settings, in particular those that minimize the burden on small entities.
- What approaches are currently used to protect workers in field-based settings? Are existing controls adequate to protect employees in these sectors? Do small entities typically rely on different controls than larger entities?

Scope Option #1: **Expand scope to include locations where embedded healthcare services are provided in correctional facilities and educational settings**

Under this option, locations with embedded healthcare settings in both educational and correctional settings, which are not currently covered by the draft regulatory framework, would be included in the scope of the standard.

The estimated additional costs under this scope alternative would amount to $46.1 million, or 3.8 percent of total annualized costs under the default scenario. For the 15,805 employers with embedded healthcare services (PCCRC employees) that would become covered by this regulatory option, the additional cost would be approximately $2,914 per employer.

ISSUES

- OSHA is interested in receiving feedback and/or any supporting data from SERs with experience in the provision of medical services within educational or correctional settings on whether OSHA should include these settings under a potential draft standard.
- OSHA welcomes input from SERs regarding the risks of WPV associated with healthcare services within correctional facilities and educational settings, and the potential need for options that include these employers within the scope of the draft standard.

4. Regulatory Summary and Costs

The draft regulatory framework OSHA is considering contains five core components of a WPV prevention program, which are based on the five core components identified in OSHA's "Guidelines for Preventing WPV for Healthcare and Social Service Workers" (available at https://www.osha.gov/sites/default/files/publications/osha3148.pdf). These five components of the regulatory framework are: (1) WPV Prevention Program (WVPP) development, implementation, and maintenance; (2) WPV Hazard Assessment; (3) Implementation of WPV Control Measures; (4) Training; and (5) Violent Incident Investigation and Recordkeeping. Table 5 presents the preliminary estimated per-establishment cost for each of the main elements of the WPV framework, by affected NAICS industry. These elements and the potential requirements of a WPV Prevention standard are discussed in more detail below and in the PIRFA.

Table 5. Total Annualized Cost per Establishment, by NAICS Industry and Draft Regulatory Framework Section (all ownerships and sizes; 3 percent discount rate)

NAICS	NAICS Description	Number of Establishments	C – WVPP Development	D – Hazard Assessment	E - Controls	F - Training	G - Investigation and Recordkeeping	Total	Healthcare Setting
--	Total	300,447	$217	$212	$349	$3,025	$245	$4,047	
621112	Offices of Physicians, Mental Health Specialists	10,817	$164	$49	$116	$663	$1	$991	Behavioral Health
621330	Offices of Mental Health Practitioners	25,370	$178	$55	$124	$580	$2	$940	Behavioral Health
621420	Outpatient Mental Health and Substance Abuse	11,969	$465	$167	$273	$1,529	$21	$2,455	Behavioral Health
621493	Freestanding Ambulatory Surgical, Emergency	7,661	$39	$52	$82	$1,390	$18	$1,581	Other Hospitals (excluding BH)
621610	Home Health Care Services	33,581	$175	$133	$30	$3,261	$19	$3,618	Home Healthcare Services
621910	Ambulance Services	5,672	$113	$84	$19	$1,572	$24	$1,811	Emergency Responders
622110	General Medical and Surgical Hospitals	5,285	$1,376	$2,452	$3,376	$67,624	$4,734	$79,563	Other Hospitals (excluding BH)
622210	Psychiatric and Substance Abuse Hospitals	1,442	$1,136	$5,446	$6,186	$10,840	$17,755	$41,362	Behavioral Health
622310	Specialty Hospitals (excl. Psychiatric, Substance)	920	$416	$813	$999	$16,546	$2,384	$21,157	Other Hospitals (excluding BH)
623110	Nursing Care Facilities (Skilled Nursing Facilities)	17,138	$639	$750	$1,324	$7,384	$237	$10,332	Residential Care Facilities
623210	Residential Intellectual, Developmental Disability	35,218	$240	$127	$333	$816	$138	$1,654	Behavioral Health
623220	Residential Mental Health and Substance Abuse	8,084	$490	$206	$374	$1,379	$200	$2,649	Behavioral Health
623311	Continuing Care Retirement Communities	5,570	$386	$447	$1,004	$4,554	$107	$6,498	Residential Care Facilities
623312	Assisted Living Facilities for the Elderly	20,052	$119	$137	$297	$1,277	$31	$1,861	Residential Care Facilities
623990	Other Residential Care Facilities	5,371	$77	$143	$282	$1,261	$380	$2,144	Residential Care Facilities
624110	Child and Youth Services	12,278	$92	$92	$301	$726	$151	$1,362	Social Assistance

Table 5. Total Annualized Cost per Establishment, by NAICS Industry and Draft Regulatory Framework Section (all ownerships and sizes; 3 percent discount rate)

NAICS	NAICS Description	Number of Establishments	C – WVPP Development	D – Hazard Assessment	E - Controls	F - Training	G - Investigation and Recordkeeping	Total	Healthcare Setting
624120	Services for Elderly and Persons with Disabilities	35,075	$92	$74	$26	$2,080	$44	$2,317	Home Healthcare Services
624190	Other Individual and Family Services	29,937	$81	$67	$250	$644	$29	$1,071	Social Assistance
624210	Community Food Services	4,790	$32	$27	$90	$304	$11	$464	Social Assistance
624221	Temporary Shelters	4,287	$68	$56	$133	$574	$31	$862	Social Assistance
624229	Other Community Housing Services	4,696	$44	$37	$100	$391	$20	$592	Social Assistance
624230	Emergency and Other Relief Services	1,112	$86	$71	$245	$720	$28	$1,150	Social Assistance
624310	Vocational Rehabilitation Services	8,011	$132	$118	$398	$935	$114	$1,696	Social Assistance
	Firefighter EMTs	6,110	$37	$85	$26	$1,952	$35	$2,135	Emergency Responders

Source: OSHA, 2023.

The following paragraphs discuss potential requirements in the draft regulatory framework.

(c) Workplace Violence Prevention Program (WVPP)

Paragraph (c) of the draft regulatory framework requires employers to establish a program to address WPV. The draft regulatory framework requires that employers develop a written WPV program (also referred to as WVPP or plan) (or update a current written WVPP), implement the WVPP (ensuring that all employees are made aware of the WVPP and are trained) and take steps for continual maintenance of the WVPP. This would be a program-oriented standard, which would allow employers to tailor the specific regulatory requirements to their own establishments, as well as allow employers to integrate the WVPP that they develop into existing injury and illness prevention programs. Under this framework, employers would have the flexibility to tailor the WVPP and its implementation to specific workplace conditions and hazards. The WVPP would focus on developing processes and procedures appropriate and specific for the size and complexity of a given facility's operation or work setting.

Paragraph (c)(2) of OSHA's draft regulatory framework identifies the specific elements that OSHA has initially identified for inclusion within the WVPP. These include:

(i) A copy of the workplace hazard assessment.

(ii) All standard operating procedures associated with the development and implementation of workplace violence control measures to address identified workplace violence hazards or risk factors.

(iii) All standard operating procedures and policies associated with recording, reporting, and investigating violent incidents.

(iv) A copy of the employer's anti-retaliation policy.

(v) Procedures to effectively communicate and coordinate with other employers at the same worksite.

(vi) Procedures to involve non-managerial employees and their representatives (if applicable) in developing, implementing, and reviewing the WVPP.

(vii) The name and job title of the designated program administrator(s).

Paragraph (c)(3) of the draft regulatory framework also includes a requirement that employers *reevaluate* policies and procedures on a regular basis (at least annually) to identify deficiencies and take corrective action, and paragraph (c)(4) specifies that employers need to allow sufficient time for employees to complete any required WVPP

activities (e.g., training, reporting, incident reviews, etc.) during regularly scheduled shifts, at a reasonable time and place.

Paragraph (c)(5) of the draft regulatory framework also specifies that employers need to notify all employees within the entire facility, regardless of duties, about the general existence of the employer WVPP and about how to report incidents to ensure employee awareness of and involvement in the program.

Table 6 summarizes OSHA's estimated facility-level labor burdens for section (c) of the draft regulatory framework. The burden estimates in Table 6 vary based on NAICS industry, ownership, and size. Large general and psychiatric hospitals have the highest burden, at an estimated average of 100 hours initially and 20 hours annually for the WVPP review. OSHA assumes facilities have an initial minimum of one hour of labor.

Table 6. Total Per-Facility Labor Burden for Section (c), labor hours (all ownerships)

NAICS	NAICS Description	Large		Small		Very Small	
		One-Time	Annual	One-Time	Annual	One-Time	Annual
621112	Offices of Physicians, Mental Health Specialists	14.4	2.9	11.4	2.3	7.9	1.6
621330	Offices of Mental Health Practitioners (except Physicians)	41.7	8.3	14.5	2.9	7.2	1.4
621420	Outpatient Mental Health and Substance Abuse Centers	67.6	13.5	37.9	7.6	11.5	2.3
621493	Freestanding Ambulatory Surgical and Emergency Centers	3.4	0.7	1.9	0.4	1.0	0.2
621610	Home Health Care Services	26.7	5.3	9.0	1.8	1.8	0.4
621910	Ambulance Services	12.6	2.5	6.6	1.3	2.2	0.4
622110	General Medical and Surgical Hospitals	100.0	20.0	17.3	3.5	1.0	0.1
622210	Psychiatric and Substance Abuse Hospitals	100.0	20.0	47.1	9.4	1.5	0.3
622310	Specialty Hospitals (excl. Psychiatric and Substance Abuse)	25.2	5.0	11.3	2.3	1.0	0.1
623110	Nursing Care Facilities (Skilled Nursing Facilities)	70.0	14.0	51.3	10.3	3.1	0.6
623210	Residential Intellectual and Developmental Disability	45.0	9.0	40.4	8.1	15.0	3.0
623220	Residential Mental Health and Substance Abuse Facilities	93.2	18.6	48.9	9.8	13.1	2.6
623311	Continuing Care Retirement Communities	70.1	14.0	33.0	6.6	3.8	0.8
623312	Assisted Living Facilities for the Elderly	28.9	5.8	9.0	1.8	3.1	0.6
623990	Other Residential Care Facilities	16.0	3.2	8.6	1.7	3.1	0.6
624110	Child and Youth Services	18.3	3.7	6.9	1.4	3.0	0.6
624120	Services for the Elderly and Persons with Disabilities	30.8	6.2	8.1	1.6	1.4	0.3
624190	Other Individual and Family Services	20.8	4.2	5.9	1.2	2.6	0.5
624210	Community Food Services	4.4	0.9	2.4	0.5	2.6	0.5
624221	Temporary Shelters	NA	NA	5.8	1.2	2.3	0.5
624229	Other Community Housing Services	1.7	0.3	3.7	0.7	1.8	0.4
624230	Emergency and Other Relief Services	12.9	2.6	2.5	0.5	2.4	0.5
624310	Vocational Rehabilitation Services	16.8	3.4	9.7	1.9	1.9	0.4
	Firefighter-EMTs	12.2	2.4	2.0	0.4	1.0	0.2

Source: OSHA, 2023.
NA = no establishments

ISSUES

- OSHA welcomes your thoughts on the draft requirements for a WVPP. Do you think a WVPP is an important component of a WPV Prevention standard? Why or why not?
- Do you agree that, if required, the WVPP should be written? Why or why not?
- Are there any elements of the WVPP that OSHA has not considered that you think should be included? If so, what are they?
- Are there any elements of the WVPP that OSHA has included that you think are unnecessary? If so, what are they? Are there other protections that should be included instead?

OSHA has included potential requirements for employers to develop procedures to communicate and coordinate their WVPP with other employers at the same worksite.

- How do you currently manage the health and safety duties and responsibilities of multiple employers at your establishment?
- OSHA is also interested in SERs' perspectives on whether and how multi-employer duties should be specified in a potential rule.

In the draft requirements for a WVPP, OSHA contemplates a requirement for employers to involve non-managerial employees and their representatives (if applicable) in developing, implementing, and reviewing the WVPP, including their participation with (A) Identifying, evaluating, and correcting workplace violence hazards; (B) Designing and implementing training and reporting procedures; (C) Investigating WPV incidents; and (D) Annually reviewing the WVPP.

- Do you currently involve employees and their representatives in the development, implementation, and review of your WVPP if you have one? If so, how are they involved? Please describe your process of involvement and review. Is this process typically successful in terms of producing a plan that is endorsed by the employer and employees and their representatives?
- Do you think OSHA should include a requirement for employee involvement? Why or why not? What benefits or challenges would you anticipate if OSHA were to include this requirement?

***WVPP Alternative #1*: Alternative timing of program review (e.g., every two years, every three years vs. annually)**

In the draft regulatory framework, employers would be required to conduct a review of their WVPP at least annually, and whenever necessary to reflect certain changes in the workplace. OSHA estimates that this comes at a total cost of $39.6 million.

OSHA could consider an alternative where employers conduct this review of their WVPP only once every other year (biennially) or every three years (triennially). The savings associated with biennial reviews would be $22.0 million per year which represents an average annual savings of 406,294 hours per year, or 1.35 hours saved per establishment. And if the program review took place every three years, the savings would be $26.8 million per year from an average annual savings of 487,553 hours per year over, or 1.62 hours saved per establishment.

ISSUES

- OSHA requests feedback from SERs about these alternatives. Do you think it's necessary to conduct a formal assessment of the WVPP annually? Why or why not?
- Do you think employees would be as protected from WPV hazards if the plan was reviewed every other year (biennially), or every three years (triennially)? Why or why not?
- If you currently conduct a period review of a similar plan, please indicate how often this review occurs and whether the review typically results in changes to the plan.

(d)Workplace Violence Hazard Assessment

Paragraph (d) of the draft regulatory framework, Workplace Violence Hazard Assessment, specifies requirements for initial establishment-wide and high-risk area hazard assessments. The draft regulatory framework specifies that paragraph (d) does not apply to home healthcare and field-based social assistance service employers, emergency medical services employers, or staffing agencies that would instead complete the hazard assessment elements as shown in two tables in the draft regulatory framework: Table E-1 for Home Healthcare and Field-Based Social Assistance Services, and Table E-2 for Emergency Medical Services.

The provisions for workplace hazard assessment would help ensure that employers proactively collect and review existing information, inspect the workplace for threats to employee safety, characterize the nature of the identified risks, and develop a plan to

mitigate identified risk factors in a timely manner. These provisions would help employers institutionalize processes and procedures known to effectively identify hazardous situations between patients, clients, and visitors and employees in the workplace and evaluate risks on a continual basis. The provisions would provide the framework for the hazard assessments and are important because one of the root causes of workplace injuries, illnesses, and incidents is the failure to identify or recognize threats to employee safety that are present or can be reasonably anticipated.

Draft paragraph (d)(1) requires employers with fixed location facilities to conduct a workplace hazard assessment to facilitate prevention of patient, client, resident or visitor-initiated violence against employees. In *Hazard Assessment* paragraph (d)(1)(iv) and in Tables E-1 (for Home Healthcare and Field-Based Social Assistance) and E-2 (for Emergency Medical Services) OSHA has included requirements for employers to evaluate employee risk for WPV based on the level and types of crime in the employer's served community. Draft paragraph (d)(2) would mandate that each employer establish and implement effective procedures to address the findings from the hazard assessments and maintain written records of these plans as they progress over time, that document the risk factors that were identified and addressed, that abatements were well reasoned and appropriate, and that any remaining risk was minimized.

A requirement for annual hazard assessments specifies that subsequent hazard assessments take place at least annually and include an assessment of the previous three years of WPV incidents. The draft regulatory framework for hazard assessments also includes a requirement for employers to provide an opportunity for employees to report any previously-unreported WPV incidents that may have occurred in the establishment during the prior three years. Such a requirement would be intended to yield a more robust and effective hazard assessment and would underscore to workers that the reporting of WPV incidents is both expected and required.

OSHA's draft regulatory framework also includes a requirement for additional hazard assessments and identifies instances in which employers would be required to conduct *additional* hazard assessments, more frequently than once a year (i.e., when there has been a WPV incident in a service area or activity not previously identified as high-risk, when certain changes are made to the worksite, or when a change in the clientele or services provided could increase WPV risk).

Finally, OSHA's draft regulatory framework for this section includes a requirement addressing hazard assessment responsibilities on a multi-employer worksite. OSHA estimates the cost of the potential hazard assessment requirements includes the time spent reviewing the WPV incident records and the time spent conducting the facility-wide hazard assessment.

Table 7 presents OSHA's estimates of per-facility compliance costs for the three-year incident review. This review, after the initial year, will be a mix of incidents previously reviewed as well as new incidents that have been recorded. OSHA preliminarily assumes this activity is undertaken by a supervisor or manager.

Table 7. WPV Incident Review Burden and Cost per Facility, Initial Year, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621112	Offices of Physicians, Mental Health Specialists	0.1	$9	0.00	$0.2	0.00	$0.1
621330	Offices of Mental Health Practitioners	0.2	$17	0.01	$0.9	0.01	$0.5
621420	Outpatient Mental Health and Substance Abuse	0.2	$13	0.08	$6.1	0.02	$1.6
621493	Freestanding Ambulatory Surgical and Emergency	0.1	$9	0.06	$4.8	0.03	$2.2
621610	Home Health Care Services	0.2	$12	0.05	$3.9	0.01	$0.7
621910	Ambulance Services	0.1	$10	0.08	$5.8	0.02	$1.9
622110	General Medical and Surgical Hospitals	18.8	$1,797	2.44	$233	0.04	$3.9
622210	Psychiatric and Substance Abuse Hospitals	76.0	$6,493	14.48	$1,236	0.79	$67.3
622310	Specialty Hospitals (excl. Psychiatric and Substance)	8.9	$874	1.29	$127	0.07	$6.4
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1.3	$93	0.81	$59.2	0.05	$3.3
623210	Residential Intellectual and Developmental Disability	1.6	$67	0.50	$20.5	0.37	$15.0
623220	Residential Mental Health and Substance Abuse	2.2	$131	0.70	$42.1	0.24	$14.6
623311	Continuing Care Retirement Communities	1.0	$60	0.43	$25.8	0.05	$2.8
623312	Assisted Living Facilities for the Elderly	0.4	$23	0.11	$6.4	0.04	$2.3
623990	Other Residential Care Facilities	7.3	$374	1.11	$57.1	0.61	$31.3
624110	Child and Youth Services	3.3	$175	0.33	$17.6	0.22	$12.0
624120	Services for the Elderly and Persons with Disabilities	0.9	$41	0.18	$8.4	0.03	$1.6
624190	Other Individual and Family Services	0.7	$37	0.05	$2.9	0.03	$1.8
624210	Community Food Services	0.0	$3	0.03	$1.6	0.01	$0.9
624221	Temporary Shelters	NA	NA	0.09	$5.3	0.03	$2.1
624229	Other Community Housing Services	0.1	$6	0.06	$3.4	0.03	$1.6
624230	Emergency and Other Relief Services	0.1	$8	0.03	$1.5	0.01	$0.8
624310	Vocational Rehabilitation Services	1.0	$58	0.37	$20.9	0.07	$4.0
	Firefighter-EMTs	0.7	$57	0.08	$5.8	0.04	$2.9

Source: OSHA, 2023.
NA = no establishments

For the facility-wide hazard assessment, OSHA estimated the time necessary to undertake this assessment as a function of facility size based on the total number of beds for general hospitals, psychiatric hospitals, and nursing homes. OSHA estimated the average number of beds per facility by size – large, small, and very small – for the three affected industries based on ratio of employment in these size categories to the overall average.

Table 8 summarizes the estimated number of beds per facility for the three affected industries, as well as average employees per facility. These data for beds and facilities were used as the inputs in subsequent analyses specifying facility size for the other affected NAICS industries.

Table 8. Average Beds per Facility, all Ownerships

Facility Type and Size	Beds per Facility	Employees per Facility
General Hospital (NAICS 622110)	150	931
Large	196	1,216
Small	31	192
Very Small	1	3
Psychiatric Hospital (NAICS 622210)	60	98
Large	70	115
Small	51	84
Very Small	3	4
Nursing Home (NAICS 623110)	135	291
Large	166	359
Small	78	169
Very Small	2	4

Source: OSHA, 2023, based on AHA (2019), CDC (2019).

For the remaining affected industries, the facility-wide assessment burden is estimated based on their employment size using the number of patient/client/resident care and contact employees per establishment (see Table 4) and comparing those totals with similar establishments discussed above to estimate of the number of beds or bed-equivalents for each NAICS industry, by facility size. Specifically, other industries in the Other Hospital setting are estimated based on employment size relative to the hospitals inputs (622110); other industries in the behavioral health setting are estimated relative to the psychiatric hospital inputs (622210); and all other industries are estimated relative to the nursing home inputs (623110).

Lastly, OSHA estimates that the facility-wide assessment will take 20 minutes per bed (or bed-equivalent) per establishment.

The time necessary to conduct the hazard assessment for the home healthcare and emergency response industries is reduced by 50 percent due to the absence of a physical facility of care.

OSHA estimates that these assessments would be mainly carried out by managers but employees will provide some input so the dollar value of labor uses a mix of management labor and employee labor, with 75 percent allocated to management.

Table 9 summarizes facility-level labor burdens and cost for the facility-wide hazard assessment. These assessments recur annually, but OSHA assumes that the level of effort and associated costs is reduced by half following the first-year assessment.

Table 91 Annual Facility-Wide Hazard Assessment Burden and Cost per Facility, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621112	Offices of Physicians, Mental Health Specialists	2.9	$257	2.3	$203	1.6	$140
621330	Offices of Mental Health Practitioners	8.3	$635	2.9	$221	1.4	$109
621420	Outpatient Mental Health and Substance Abuse	13.5	$864	7.6	$485	2.3	$146
621493	Freestanding Ambulatory Surgical and Emergency	0.7	$49	0.4	$27	0.2	$13
621610	Home Health Care Services	5.3	$341	1.8	$114	0.4	$23
621910	Ambulance Services	2.5	$158	1.6	$101	0.4	$27
622110	General Medical and Surgical Hospitals	20.0	$1,699	3.5	$294	0.1	$5
622210	Psychiatric and Substance Abuse Hospitals	20.0	$1,504	9.4	$708	0.3	$23
622310	Specialty Hospitals (excl. Psychiatric and Substance)	5.0	$434	2.3	$194	0.1	$6
623110	Nursing Care Facilities (Skilled Nursing Facilities)	14.0	$861	10.3	$630	0.6	$38
623210	Residential Intellectual and Developmental Disability	9.0	$315	8.1	$283	3.0	$105
623220	Residential Mental Health and Substance Abuse	18.6	$933	9.8	$489	2.6	$131
623311	Continuing Care Retirement Communities	14.0	$701	6.6	$330	0.8	$38
623312	Assisted Living Facilities for the Elderly	5.8	$289	1.8	$90	0.6	$31
623990	Other Residential Care Facilities	3.2	$141	1.7	$76	0.6	$28
624110	Child and Youth Services	3.7	$166	1.4	$63	0.6	$27
624120	Services for the Elderly and Persons with Disabilities	6.2	$250	1.6	$65	0.3	$12
624190	Other Individual and Family Services	4.2	$189	1.2	$54	0.5	$23
624210	Community Food Services	0.9	$44	0.5	$25	0.5	$26
624221	Temporary Shelters	0.0	$0	1.2	$58	0.5	$23
624229	Other Community Housing Services	0.3	$17	0.7	$38	0.4	$18
624230	Emergency and Other Relief Services	2.6	$131	0.5	$25	0.5	$24
624310	Vocational Rehabilitation Services	3.4	$159	1.9	$92	0.4	$18
	Firefighter-EMTs	2.4	$157	0.4	$26	0.2	$11

Source: OSHA, 2023.
NA = no establishments

Table 10 presents OSHA's estimates of total per-facility costs to comply with section (d) of the regulatory framework which includes the cost of the WPV incident review and the facility-wide hazard assessment.

Table 10 Total Per-Facility Hazard Assessment Cost, Initial Year, by NAICS Code, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621112	Offices of Physicians, Mental Health Specialists	14.4	$1,283	11.4	$1,017	7.9	$702
621330	Offices of Mental Health Practitioners	41.7	$3,173	14.5	$1,106	7.2	$544
621420	Outpatient Mental Health and Substance Abuse	67.6	$4,319	37.9	$2,424	11.5	$732
621493	Freestanding Ambulatory Surgical, Emergency	3.4	$247	1.9	$137	1.0	$64
621610	Home Health Care Services	26.7	$1,704	9.0	$572	1.8	$117
621910	Ambulance Services	12.6	$790	8.0	$504	2.2	$136
622110	General Medical and Surgical Hospitals	100.0	$8,494	17.3	$1,469	1.0	$27
622210	Psychiatric and Substance Abuse Hospitals	100.0	$7,520	47.1	$3,539	1.5	$116
622310	Specialty Hospitals (excl. Psychiatric, Substance)	25.2	$2,170	11.3	$969	1.0	$30
623110	Nursing Care Facilities (Skilled Nursing Facilities)	70.0	$4,305	51.3	$3,152	3.1	$188
623210	Residential Intellectual, Developmental Disability	45.0	$1,574	40.4	$1,414	15.0	$525
623220	Residential Mental Health and Substance Abuse	93.2	$4,664	48.9	$2,447	13.1	$656
623311	Continuing Care Retirement Communities	70.1	$3,506	33.0	$1,650	3.8	$189
623312	Assisted Living Facilities for the Elderly	28.9	$1,446	9.0	$450	3.1	$154
623990	Other Residential Care Facilities	16.0	$707	8.6	$380	3.1	$139
624110	Child and Youth Services	18.3	$828	6.9	$314	3.0	$135
624120	Services for Elderly and Persons with Disabilities	30.8	$1,250	8.1	$327	1.4	$59
624190	Other Individual and Family Services	20.8	$944	5.9	$268	2.6	$116
624210	Community Food Services	4.4	$220	2.4	$123	2.6	$132
624221	Temporary Shelters	0.0	$0	5.8	$290	2.3	$114
624229	Other Community Housing Services	1.7	$86	3.7	$188	1.8	$92
624230	Emergency and Other Relief Services	12.9	$653	2.5	$126	2.4	$120
624310	Vocational Rehabilitation Services	16.8	$794	9.7	$460	1.9	$91
	Firefighter-EMT	12.2	$785	2.0	$131	1.0	$54

Source: OSHA, 2023.

ISSUES

- OSHA welcomes SERs' feedback on the potential requirements for hazard assessments. Do you agree that hazard assessments are an important component of a WVPP? Why or why not?

- Do you perceive the potential requirements for annual hazard assessments to be problematic? Please explain.

- Do you think OSHA's estimate that the hazard assessment will take 20 minutes per bed (or bed-equivalent) is accurate? If not, what do you think would be a more appropriate estimate? What do you expect would need to be done that would take that amount of time?

- Should the provision for reporting previously-unreported incidents be included? Why or why not? Do you perceive any difficulties arising from such a provision? Please specify

- What type of information about crime in the surrounding community is typically provided to employees? Are there specific steps that employees are encouraged to take for their safety when arriving at, or leaving, a facility? When there are patients or clients identified as potentially posing a risk to staff, are there specific measures to limit or otherwise address interactions with those patients or clients in the outside areas surrounding the facility?

- Are the level and types of crime in the employer's served community are relevant risk factors for employers to evaluate as an element of their workplace hazard assessment? Why or why not? If OSHA requires assessment of crime in the surrounding community, are there specific measures you recommend for this purpose?

- Are there other factors that OSHA should require employers to consider, either in establishment-based or field-based hazard assessments, that are not included in this draft regulatory framework? If so, what are they and why do you think they are important?

- OSHA believes that patients and clients (and their families or other legally designated decision-makers) are sometimes required to agree to provide a safe environment for home healthcare employees as a formal condition of receiving home healthcare services. Does this align with your experiences? What happens if such agreement is in place but employees have concerns about the safe environment upon arrival? Have WPV incidents, or situations that appeared to be moving in that direction, occurred in locations with those types of agreements? Are there other measures that OSHA should consider to protect employees during visits to provide services in the home of a patient or client?

Under OSHA's draft regulatory framework home healthcare and social assistance services employers must ensure that that hazard assessment and control measures in Table E-1 are implemented. The elements in Table E-1 include reviewing past WPV incidents, evaluating work practice controls and PPE, adequacy of communication devices, and levels of crime in the surrounding community, and implementing various standard operating procedures, including procedures associated with anticipation of risk, summoning assistance, and discontinuing a visit.

- In your experience, do employers of home healthcare workers and field-based social assistance workers typically ensure that all of the hazard assessment and control measures in Table E-1 are implemented? Why or why not? If not, do you have recommendations for how to improve employer use of hazard assessments in these settings? Are there particular obstacles to implementing assessments?
- What are current practices for hazard assessment in this sector? Are such elements already generally considered? What protections and controls are generally implemented? Are there any additional hazard assessment or control measure elements that OSHA should either add or remove from Table E-1 with respect to home healthcare workers?

The working environment for emergency medical service workers may also be tremendously variable and unpredictable. Such services are often performed in private residences or public settings where most engineering controls are not possible or appropriate, and EMS employees providing these services may have no background information regarding persons needing their help. These employees make assessments and decisions quickly based on the immediate circumstances. Under OSHA's draft regulatory framework, employers must ensure that hazard assessment and control measures in Table E-2 are implemented for emergency medical service workers including reviewing past WPV incidents, evaluating work practice controls and PPE, adequacy of communication devices, and levels of crime in the surrounding community, and implementing various standard operating procedures, including procedures associated with anticipation of risk and summoning assistance when necessary.

- Is it reasonable to expect employers of emergency medical services workers (or firefighters cross-trained in EMS) to ensure that all hazard assessment and control measures in Table E-2 are implemented? If not, are there some elements you believe can and should be adhered to? Which ones are these and why?
- What are current practices for hazard assessment in this sector? Are the elements in Table E-2 already generally considered? What protections and controls are generally implemented? Are there any additional hazard assessment or control measure elements that OSHA should either add or remove from Table E-2 with respect to emergency medical services workers?
- Would the hazard and control elements in Tables E-1 (for Home Healthcare and Field-Based Social Assistance) and E-2 (for Emergency Medical Services) in the draft regulatory text ensure a higher-degree of worker protection than what currently exists in these industry sectors?
- Are there additional requirements for hazard assessment or controls for Tables E-1 or E-2 in the draft regulatory text that OSHA should consider? Are there specific requirements that OSHA should consider removing?

- Does your establishment operate or contract with non-emergency transport services for patient/client/resident purposes? Please describe these services. Is it appropriate for OSHA to consider such transport services for inclusion to a potential future proposed rule?

***Hazard Assessment Alternative #1*: Annual hazard assessments consider one year or two years of incident data, rather than three years of data.**

OSHA's draft regulatory framework specifies that employers would be required to review three years of their WPV incidents including credible threats of physical harm that occurred in their establishment as part of their annual assessment.

Here, OSHA presents an alternative that employers would be required to review either one or two years (instead of three years) of WPV incidents during each annual hazard assessment. OSHA estimates that the savings associated with reviewing just one year-worth of data would be $5.7 million reducing the number of hours spent on these reviews by 140,044 hours per year, or 0.47 hours per facility per year. The savings associated with reviewing only two years-worth of incidents would be $2.8 million which translates to a total savings of 70,472 hours per year, or 0.23 hours per facility per year.

ISSUES

- OSHA requests feedback from SERs about this alternative. Should OSHA require the assessment of three years of data on WPV incidents or would a review of one or two years of data be adequately protective? Why or why not?

***Hazard Assessment Alternative #2*: Employers would only focus on OSHA-defined high-risk service areas and not be expected to identify additional high-risk service areas based on previous occurrence of workplace violence**

The draft regulatory framework defines "High-risk service areas" as:

> *settings where there is an elevated risk of workplace violence incidents. These services and settings include emergency rooms/emergency admissions/triage areas, psychiatric care, behavioral healthcare, substance abuse treatment, home healthcare, social assistance, emergency medical services, and other services deemed to be of high-risk for violence by the employer. An area where a workplace violence incident has occurred in the previous three years is high-risk unless the employer has a written determination demonstrating that this designation is not appropriate.*

In addition to the hazards and risk factors that must be considered for all covered facilities at a minimum, the employer must assess all high-risk service areas for the following risk factors under paragraph (d)(vi):

> *(A) Poor illumination or areas with blocked or limited visibility;*
> *(B) Employee staffing patterns that are inadequate to reduce workplace violence or respond to workplace violence incidents;*
> *(C) Lack of physical barrier protection between employees and patients/visitors in areas such as admission, triage, and nursing stations;*
> *(D) Lack of effective escape routes;*
> *(E) Entryways where unauthorized entrance may occur, such as doors designated for staff entrance or emergency exits; and*
> *(F) Presence of unsecured furnishings or other objects that could be used as weapons.*

Under this alternative, OSHA would not require employers to designate additional areas as high-risk based on their own establishment-level experience of WPV incidents. Furthermore, there would be no requirement for employers to assess for the issues outlined in paragraph (d)(vi) [e.g., poor illumination, staffing patterns, physical barriers, escape routes, unsecured furnishings, etc.] in any area not pre-determined by OSHA to be a high-risk service area. Assessments and implementation of controls associated with high-risk service areas would be required solely for the OSHA-defined high-risk service areas (emergency rooms/emergency admissions/triage areas, psychiatric care, behavioral healthcare, substance abuse treatment, home healthcare, social assistance, and emergency medical services).

If an incident occurred outside of the OSHA-defined high-risk services, the only requirement would be for recordkeeping and incident review of all incidents, without designation of high-risk service areas. Employers would still perform a facility-wide assessment but would not need to designate additional high-risk areas beyond those as defined by OSHA.

As noted in the PIRFA, OSHA would have significant concern with such a framework, since if an employer was experiencing incidents outside of the OSHA-defined high-risk service areas of their establishment, there would be no requirement for the employer to implement the control methods identified in paragraph (e)(3) for high-risk areas. Nonetheless, OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with such a framework.

The savings associated with this alternative approach to identification of WPV hazards, without any specific regard to where employers should focus their interventions, would be $49.3 million – with a percent change of annualized cost of -4.1 percent.

ISSUES

- OSHA requests feedback from SERs on this alternative. Would it be beneficial to employers and improve employee safety and health to not have designated high risk service areas but rather focus on all aspects in all areas of the facility? Why or why not?

Hazard Assessment Alternative #3: **Change the definition of high-risk service area -- No requirement for employers to conduct hazard assessments based on OSHA's pre-determinations of high-risk service areas; hazard assessments would be directed to employer-defined high-risk service areas only**

Quite the opposite of *Hazard Assessment Alternative #2*, *Hazard Assessment Alternative #3* would require employers to focus their WPV assessments exclusively upon high-risk areas. Under this alternative, OSHA would change the definition of high-risk service area to only include areas determined to be high-risk by the employer (i.e., an area where a WPV incident has occurred in the previous three years), and would not include any areas pre-determined by OSHA. Emergency rooms/emergency admissions/triage areas, psychiatric care, behavioral healthcare, substance abuse treatment, home healthcare, social assistance, and emergency medical services could still be determined to be high-risk areas, but only if they had experienced a WPV incident in the last three years. This change in definition would mean that employers would only need to conduct the extra assessments in (d)(1)(vi) for areas that the employer had identified as high-risk because of the occurrence of a WPV incident. The employer would still be required to complete all other steps in the initial assessment (paragraph (d)(1)(i)-(v)), annual hazard assessments (paragraph (d)(3)) and additional hazard assessments (paragraph (d)(4)), with the only change being to the definition a high-risk service area.

OSHA estimates that the savings associated with this more focused approach to identification of WPV hazards, would amount to $157.3 million – with a percent change of annualized cost of -12.9 percent.

ISSUES

- OSHA welcomes feedback from SERs about this alternative. Would you prefer to be able to define a high-risk service area for your facility? Or would you prefer OSHA offer some parameters for which areas should be considered high-risk? Please explain.
- Should OSHA adopt this alternative and allow employers to forgo the full hazard assessment for areas not designated as high-risk service areas (as determined by review of incidents)? Why or why not? Would this be as protective for workers?

(e) Control Measures

Section (e) of OSHA's draft regulatory framework addresses Control Measures. Under this draft section, employers must consider and implement WPV control measures to correct WPV hazards throughout the facility or other site of care, which are based on hazard assessment findings.

The draft requirements for control measures are organized into categories: (1) engineering controls (physical changes to the workplace), (2) administrative and work practice controls (changes to the ways staff perform jobs or tasks), and (3) personal protective equipment (PPE), such as protective face-wear, bite-resistant sleeves, etc. Engineering, administrative, and work practice controls are aimed at eliminating or minimizing employee exposure to identified hazards for a given facility. Several control requirements (e.g., personal panic alarms, security policies, response planning) only apply to high-risk areas.

OSHA anticipates that a facility may need to procure specific equipment and/or services in order to comply with the control measure requirements. Specifications that OSHA expects to result in control costs include:

Designing the physical layout of public areas in the workplace, including waiting rooms and hallways, such that room configuration, furniture dimensions, or other floor arrangements do not impede employee observation of activity within the facility. This requirement includes the removal of sight barriers, the provision of surveillance systems or other sight aids such as mirrors, improved illumination, and the provision of alarm systems or other effective means of communication where the physical layout prevents line of sight;

Ensuring that employees have unobstructed access to alarms and exit doors as a means to escape violent incidents;

Ensuring that video surveillance equipment, if any, is operable for the purpose it is intended;

Removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons in areas where direct patient/client/resident contact/care activities are performed;

Installing protective barriers between employees and patients/visitors in areas such as admission, triage, and nursing stations;

Installing, implementing, and maintaining the use of an alarm system, personal panic alarms, or other effective means of emergency communication for employees with direct patient/client/resident care/contact duties;

Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patients/clients are reasonably anticipated to possess unauthorized firearms or other weapons. This could include monitoring and controlling designated public entrances by use of safeguards such as metal detection devices, remote surveillance, alarm systems, or a registration process to limit access to the facility by unauthorized individuals conducted by personnel who are in an appropriately protected workstation;

Ensuring that there are staff members who can respond immediately to WPV incidents; and

Ensuring employee staffing patterns are sufficient to address WPV hazards in high-risk service areas.

OSHA estimated unit costs for the range of control equipment that will be needed to meet the requirements indicated above.

Table 11 presents the set of control equipment included in the analysis along with the unit cost for each type of control equipment, which in some cases vary by the size of the equipment or system.

Table 112 Engineering and Work Practice Control Equipment Unit Costs

Control Name	Unit Cost	Units
Indoor lights	$250	Per new indoor light fixture
Outdoor lights	$700	Per new outdoor light fixture
Circular or curved mirrors	$50	Per mirror
Electronic access controls		
Small	$1,000	Per system
Large	$2,000	Per system
Enclosed workstations with shatter-resistant glass	$250	Per workstation
Deep service counters	$8,000	Per counter
Opaque glass in patient rooms	$25	Per room
Separate rooms or areas for high-risk patients	$500	Per room
Two-way radios	$50	Per radio
Paging system		
Small	$900	Per system
Large	$3,900	Per system
Personal panic devices	$50	Per panic device
Weapon detector, handheld	$150	Per handheld detector
CCTV System		
Small	$1,000	Per system
Large	$8,000	Per system
Locks on doors	$225	Per lock
Note: See Appendix D for sources and details		

Source: OSHA, 2023.

OSHA's preliminary cost analysis involved estimating the number of each type of control equipment that would be necessary for facilities to comply with section (e) of the regulatory framework. OSHA's current estimates are based on limited information and OSHA welcomes SERs to comment on the accuracy of the cost estimates associated with all of these controls. It would be particularly useful for SERs to submit cost information based on the cost of such controls at your own entity or establishment.

Facilities even within the same industry and employee size category can exhibit a high level of variability with respect to the size and layout of their physical facility and surrounding grounds as well as the particular type and cost of controls required to meet facility-specific needs. In addition, the draft rule allows for some discretion by employers in identifying high-risk areas and assessing the optimal set of controls to mitigate risks.

The control requirements in section (e) are not applicable to home healthcare or home/field-based social assistance, or emergency responder employers; these establishments would be subject to the control requirements specified in Table E-1 and Table E-2 of the draft regulatory framework. Tables E-1 and E-2 specifically require

communication devices – specifically two-way radios and personal panic devices. OSHA only estimated costs for these two types of controls for home healthcare and emergency response. EMS and/or firefighters cross-trained as EMS are assumed to already be provided with all needed communication devices.

Table 12 summarizes OSHA's approach for estimating the number of each control required, on average, per facility.

Table 12 3 Methodological Assumptions Underlying Engineering and Work Practice Control Equipment Unit Costs

Control Name	Approach for Facility Equipment Estimates
	Each facility is assigned a quantity of controls equal to . . .
Two-way radios	10% of patient/client/resident care and contact employees per facility
Personal panic devices	10% of patient/client/resident care and contact employees per facility
Paging system	25% of patient/client/resident care and contact employees per facility
Electronic access controls	25% of patient/client/resident care and contact employees per facility
Enclosed workstations with shatter-resistant glass	An assumption of 2 workstations for large psychiatric hospitals, and scaling other industries and sizes based on their relative size indicated by the number of high-risk beds per facility
Deep service counters	An assumption of 2 counters for large psychiatric hospitals, and scaling other industries and sizes based on their relative size based on the number of high-risk beds per facility.
Locks on doors	An assumption of 25 locks for large psychiatric hospitals, and scaling other industries and sizes based on their relative size based on the number of high-risk beds per facility.
CCTV System	An assumption of 1 system for large psychiatric hospitals, and scaling other industries and sizes based on their relative size based on the number of total beds per facility (see Table 16).
Indoor lights	An assumption of 25 lights for large psychiatric hospitals, and scaling other industries and sizes based on their relative size based on total beds per facility.
Outdoor lights	An assumption of 15 lights for large psychiatric hospitals, and scaling other industries and sizes based on their relative size based on total beds per facility.
Separate rooms or areas for high-risk patients	5% of the number of high-risk beds per facility
Opaque glass in patient rooms	10% of the number of high-risk beds per facility
Circular or curved mirrors	5% of the number of high-risk beds per facility
Weapon detector, handheld	An assumption of 1 handheld detector for large psychiatric hospitals, and scaling other industries and sizes based on total beds per facility. In addition, OSHA assumes that a subset of facilities will require weapon detectors including 100% of behavioral health, 83% of other hospitals, 69% of residential care facilities, and 34% of social assistance facilities.[1]
[1] 83% is the percentage of general hospitals with an emergency department, per AHA (2019); 69% is the percentage of residential care facilities providing mental health services, and 34% is the percentage of social assistance facilities providing mental health services (CDC 2019).	

Source: OSHA, 2023.
Note: "Beds" here are either actual beds or "bed-equivalents" as discussed in the PIRFA.

The number of equipment units assigned to each facility was estimated as the number of units required beyond what facilities might otherwise have in place. For example, OSHA

did not specify the total number of lights required for a hospital, but rather the number of additional lights a facility might need to comply with the rule. At the same time, OSHA recognizes that facilities may already have sufficient controls in place to address the requirements. OSHA accounts for baseline compliance with respect to these additional controls.

Per-facility costs are a function of 1) the equipment unit cost, 2) the number of units per facility, and 3) the cost for installation estimates as 20 percent of the purchase price. Some controls (enclosed workstation, weapon detector, etc.) can only be purchased in indivisible units. Average per-facility costs typically will represent a mixture of facilities who buy the control and those who purchase none. Table 25 in Section IV of the PIRFA summarizes average total equipment costs per facility. Appendix E in the PIRFA includes detailed tables with costs by type of equipment.

In addition to control equipment, OSHA estimates the additional labor burden and cost to respond to WPV per paragraph (e) of OSHA's draft regulatory framework. OSHA bases this estimate on the estimated number of WPV incidents per facility (see Table 14 in the PIRFA) and an assumption that each incident would require on average a total of 0.75 hours of response from patient/client/resident care or contact employees (e.g., 3 people, 15 minutes each, for example). This cost applies to all facilities except for those in the home healthcare and emergency response settings and is an annually recurring burden and cost.

ISSUES

OSHA requests SER comments on the appropriateness as well as input on cost information for the control measures OSHA has contemplated for this draft rule.

In Control Measures paragraph (e)(1)(ii)(F) and in Tables E-1 (for Home Healthcare and Field-Based Social Assistance) and E-2 (for Emergency Medical Services), OSHA has contemplated requirements such as implementing effective incident response procedures. These include standard operating procedures for obtaining assistance from the appropriate law enforcement agency during all work shifts.

- OSHA seeks SER input on how and if this is a current or prevalent industry practice. In which circumstances is such assistance is sought? How often would you say such assistance is sought?

- Are there any circumstances where obtaining assistance from the appropriate law enforcement agency is specifically inadvisable?

- Overall, do you think this requirement is appropriate to include in a potential WPV Prevention standard? Why or why not?

In its draft Control Measures requirements, OSHA includes a requirement for effective communication of a patient/client/resident's history and/or potential for violence on patient charts or clients' case histories for all relevant staff via flagging (electronic or otherwise) and/or visible cues placed in or adjacent to a patient's room to indicate such propensities.

- OSHA seeks feedback on this potential requirement. What types of visual cues are currently used in the healthcare and social assistance sectors? Do you use any types of visual cues in your facility? Have you found such cues to be helpful in reducing the risk of WPV?

- Do you think it's appropriate for OSHA to include a requirement on communication of patient/client/resident history or potential for violence in a potential WPV Prevention standard? Why or why not?

- Are there specific approaches that OSHA should require or, conversely, not include, in a potential WPV Prevention standard? Please explain.

In its draft Control Measures requirements, OSHA has also included a requirement for employers to establish and implement policies and procedures for effective communication of a patient/client/resident's history or potential for violence to all *subsequent external* healthcare employers that a patient may be referred to. One potential approach to achieve this would be to implement a flagging alert program to communicate violence-related risks to healthcare and social teams associated with patients' or clients' subsequent treatment or services. OSHA believes that many healthcare and social assistance employers use computerized systems that allow for service providers to enter patient/client/resident data associated with propensity for violent behaviors that will indicate as an electronic flag to alert subsequent providers.

- OSHA welcomes SER input on this potential requirement. To what extent do the healthcare and social assistance sectors currently communicate a patient/client/resident's history or potential for violence to external healthcare providers? How is this currently done?

- Do you think this is a requirement OSHA should include in a potential WPV Prevention standard? Why or why not?

- Would this requirement provide a meaningful extra layer of protection for workers from WPV? Why or why not?

- If OSHA includes such a requirement in a standard, how could OSHA mitigate privacy concerns, if any, while still protecting workers from violence?

Control Measures Alternative #1: **Require only hazard assessment, workplace violence prevention plan, incident investigation, and training.**

Under this alternative, an employer would not be required to make modifications to mitigate identified hazards and risks (e.g., implementing engineering and administrative/work-practice controls). However, employers would still be required to conduct hazard assessments to serve as the basis for site-specific training for employees. This alternative would focus upon the employer-development of plan, employee participation, training, recording, and evaluation based on hazards identified in the hazard assessment. This alternative would remove the requirements under paragraph (e) Control measures.

OSHA views this option with significant disfavor, as it would not require a number of control measures that OSHA believes would further reduce the WPV hazard. However, OSHA requests feedback from SERs about this alternative.

OSHA estimates that the savings associated with this approach would amount to $101.7 million, or $338.39 per facility – with a percent change of annualized cost of -8.4 percent.

Control Measures Alternative #1a: **Require implementation of administrative/work-practice controls but do not require engineering controls.**

Under this alternative, the employer would not be required to implement environmental or engineering controls. This alternative would instead focus on employers implementing administrative/work-practice controls (adjusting staffing patterns, communication practices, incident response procedures, etc.), developing a WVPP, promoting employee participation, training, recordkeeping, and program evaluation.

OSHA estimates that the savings associated with this approach would amount to $94.0 million – with a percent change of annualized cost of -7.7 percent.

Control Measures Alternative #1b: **Require that employers implement a limited set of environmental or engineering controls.**

Under this alternative, OSHA could require a clearly defined, limited set of environmental or engineering controls to address a number of specific hazards. Employers would need to conduct a hazard assessment and implement *at least one* of the controls applicable to the hazard (to the extent that any are applicable), but would not be

required to implement *all* of the controls that could potentially be applicable. For example, if OSHA offers two controls for addressing the potential danger of interactions with patients or clients in a room or area not visible to others, OSHA might recommend the installation of closed-circuit surveillance systems, curved mirrors located to allow others to monitor that space, or a personal panic alarm system with nearby staff to assist quickly. The employer would then be required to assess the variables in their particular space and select at least one of those controls to address the recognized hazard, but would not need to select more than one even if doing so would provide more layers of protection (e.g., the employer would not be required to install both a closed-circuit surveillance system *and* a personal panic alarm system with staff nearby).

Because OSHA has not determined a specific list of required environmental or engineering controls nor determined where those controls might be required, the agency has not attempted to estimate the costs associated with this potential alternative. However, OSHA expects that it would fall between the estimated costs of the draft regulatory framework ($1.22 billion) and those estimated in Control Measures Alternative #1a ($1.12 billion) (see Table 2).

ISSUES

- OSHA requests feedback from SERs about an approach, such as OSHA contemplates in Alternatives # 1, 1(a), and/or 1(b) above, that would require employers to address WPV through development of a plan, employee participation, training, recordkeeping, and evaluation, but that would not require the employer to implement engineering controls or administrative/work practice controls. Do you agree with this approach? Why or why not?
- Would this approach reduce the risk of WPV incidents and protect workers to the extent that no other controls would be necessary? Please explain.
- Are there specific measures that must be included in a WVPP to ensure the plan and training provide the same protection for employees that would be provided through specified environmental, engineering, and administrative/work practice controls.
- Are there specific engineering or work practices that you perceive as less effective in preventing WPV than others? If so, which should OSHA include, and which could be eliminated without decreasing employee protections? Please explain your thinking.
- Are there workplace violence prevention control measures (administrative controls, engineering controls, PPE) that have been implemented at your establishment which have been found to be particularly effective or impactful?

Are there any supporting data you can point to either from your own establishment, in the literature, or elsewhere?

- Are there specific environmental or engineering controls that OSHA should require in some or all covered settings? Which engineering controls are the most impactful in protecting workers? Are there any settings where OSHA should mandate the use of specific engineering controls?

Control Measures Alternative #2: **Removal of requirement for all employers to develop standard operating procedures for mass shooter/mass casualty incidents**

The draft regulatory framework that OSHA has provided in this package for SER review includes a potential requirement under paragraph (e) Control measures that requires employers establish and implement standard operating procedures to respond to mass casualty threats, such as active shooters.

This alternative would remove that requirement.

OSHA believes that emergency planning for mass casualty scenarios are already a standard practice in many healthcare establishments. This draft framework focuses on Type II violence (violence perpetuated by patients/clients and their visitors upon employees), while existing emergency planning for mass casualty scenarios may or may not be focused on Type II violence.

OSHA estimates that the savings associated with the removal of the requirement would amount to $10.0 million – with a percent change of annualized cost of -0.8 percent.

Control Measures Alternative #3: **Removal of requirement for small business entities (only) to develop a standard operating procedure for mass casualty threats**

Similar to the alternative above, this alternative would exempt employers classified as a small entities from the requirement to develop standard operating procedures for mass casualty threats such as active shooters. In this alternative, employers that did not meet the criteria of a small entity would still be required to implement a standard operating procedure for mass shooter/mass casualty situations as specified in the draft regulatory framework.

OSHA estimates that the savings associated with this alternative would amount to $1.0 million – with a percent change of annualized cost of -0.1 percent.

(f) Training

Section (f) of the draft regulatory framework would require that employers institute a training program for employees with direct patient/client/resident contact, direct

patient/client/resident care, and/or WPV incident response duties, along with their supervisory staff. The training program is contemplated to include the following elements:

Under draft paragraph (f)(1), training would be required to occur initially, prior to the time of assignment to tasks where occupational exposure may take place. In addition, affected employees would be required to participate in training at least annually and in some cases more frequently if changes in the job duties or other circumstances require supplemental training.

Under the draft framework, the initial training program would need to reflect the level of risk to employees and the duties that they are expected to perform. OSHA expects this would result in different types or levels of training for employees and supervisors with patient/client care and contact duties.

For example, under the draft framework, OSHA contemplates that employees within certain occupational categories who are working in high-risk service areas would need to receive an "intermediate" level of training. OSHA expects this would result in different types or levels of training for employees in different occupational categories that reflect a mix of high-risk and non-high-risk service area employees.

Employees and supervisors assigned incident response duties or assigned to an incident response team would be required to receive an "advanced" level of instruction encompassing all types of training already potentially required and adding on advanced practical training in de-escalation, chemical and physical restraints, and procedures that are applicable to the response team.

Under the draft regulatory framework, training would be required to be overseen or conducted by a person knowledgeable in the program's subject matter as it relates to the workplace.

The costs to train employees includes the cost for employees' time during the training. The number of employees trained annually for a given facility is based on the number of patient/client/resident care employees, patient/client/resident contact employees, employees who may have incident response responsibilities, and their supervisory employees. As noted above, the nature of the required training varies for different groups of trainees. OSHA specifically estimates trainee labor burden – the number of required hours of training per trainee– for four categories of employees:

Non-high-risk service area patient/client/resident care employees and their supervisors;

Patient/client/resident contact employees and their supervisors;

High-risk service area patient/client/resident care employees and their supervisors; and

Employees who may have incident response responsibilities.

The estimated number of annual hours of training for each category of trainee is shown below in Table 13. OSHA estimates training hours for the initial training and for the subsequent annual refresher training. OSHA estimates that standard training in non-high-risk areas take four hours for patient/client/resident care employees and two hours for patient/client/resident contact employees, as well as their respective supervisors. High-risk service area patient/client/resident care employees and their supervisors get intermediate training which OSHA estimates takes twice as long as standard training. The refresher training is assumed to be half of the initial training hours.

Table 134 Standard and Intermediate Training Hours, by Employee Category

Training Type	Hours-Initial	Hours-Refresher
High-Risk Patient/Client/Resident Care Employee and Supervisor	8	4
Non-High-Risk Patient/Client/Resident Care Employee and Supervisor	4	2
Patient/Client/Resident Contact Employee and Supervisor	2	1

Source: OSHA, 2023.

With respect to the intermediate training for employees in high-risk service areas, OSHA estimated that 100 percent of patient/client/resident care employees in behavioral health settings, 45 percent of residential care patient/client care employees, and 20 percent of patient/client/resident care employees in other settings participate in the intermediate training. OSHA expects that no patient/client/resident contact-only employees will need to participate in the intermediate training.

OSHA estimated the cost for employee training time per-facility both initially (year one), and for subsequent years to reflect refresher training and initial training for new hires. The cost in subsequent years assumes that 35.5 percent of employees receive the initial training each year, and 64.5 percent receive the refresher training based on an estimated employment turnover rate of 35.5 percent for the healthcare and social assistance industry in 2018 (BLS 2019c).

Training costs include the cost of trainers that provide the instruction based on the overall number of patient/client/resident care, patient/client/resident contact, and related supervisory employees per facility, as well as the number of trainees that can be taught by a trainer at one time (classroom size.)

To estimate the cost to employers for supplying the required trainers, OSHA applied two assumptions.

- In most cases, OSHA assumes that facilities will hire outside trainers who can train 20 employees at a time and are paid a training specialist wage for the NAICS code (see Table 7 in the PIRFA).

- OSHA anticipates that some, particularly large, employers may comply with the training requirements by developing in-house trainers who may also be assigned to incident response teams. OSHA assumes that large general and specialty hospitals and all psychiatric hospitals will use this approach. OSHA preliminarily estimates that two percent of all patient/client/resident care/contact employees in facilities affected by this requirement will receive this training in classes of 20 employees and subsequently serve on response teams. The wage estimate for the trainer in this case was based on the direct patient/client/resident care occupation category.

  There would also be an additional cost for each such in-house trainer to become certified through intensive training. The unit costs of compliance for employees undergoing this intensive training include an annual training course cost, as well as the cost of labor for the time spent during the certification course. Based on consultation and input from subject matter experts, OSHA estimated that in-house trainers on an incident response team will require:

  - A three-day certification program at a cost of $1,750 per employee, plus 24 hours of class time, for employees seeking certification as in-house trainers; and,

  - A one-day re-certification program at a cost of $750 per employee, plus 8 hours of class time for current in-house trainers obtaining retraining every three years. OSHA assumes that employees previously designated as in-house trainers have an annual turnover rate of 18 percent (approximately half of the overall employee turnover rate cited above) meaning that each year approximately 18 percent of in-house trainers are replaced, requiring newly selected staff to take the full 24-hour course; OSHA also therefore assumes 82 percent of in-house trainers take the re-certification every three years, or about 27 percent each year.

For additional detail on these estimates, please see the PIRFA. OSHA's analysis recognizes that employees designated to become in-house trainers do not also need to be a participant in the training described in the draft regulatory text.

In OSHA's cost model, where employers are assumed to use outside trainers, those facilities do not incur the additional cost for developing in-house trainers nor will they have incident response teams.

Using in-house trainers versus outside trainers adds a significant cost for hospitals, the one group that OSHA estimated will use this method. The first-year cost for large general hospitals, for example, is $58,000 per facility, on average, with in-house trainers, versus $11,000 for outside trainers. OSHA expects that some larger employers will opt for this approach regardless of the higher cost because these in-house trainers could then be available to make up the specialized incident response teams and may be able to give standard training to fellow employees.

Table 14 summarizes total training costs per employee trained, in year one and subsequent years, including both trainer- and trainee-related costs.

Table 145 Total Training Cost per Employee, all Ownerships ($2019)

NAICS	NAICS Description	Large Facility		Small Facility		Very Small Facility	
		First Year	Subse-quent Years	First Year	Subse-quent Years	First Year	Subse-quent Years
621112	Offices of Physicians, Mental Health Specialists	$700	$472	$753	$503	$755	$504
621330	Offices of Mental Health Practitioners	$476	$321	$544	$360	$668	$434
621420	Outpatient Mental Health and Substance Abuse	$364	$245	$372	$250	$424	$280
621493	Freestanding Ambulatory Surgical, Emergency	$272	$183	$280	$188	$312	$207
621610	Home Health Care Services	$167	$112	$167	$112	$205	$134
621910	Ambulance Services	$158	$106	$162	$108	$182	$120
622110	General Medical and Surgical Hospitals	$324	$188	$270	$182	$337	$221
622210	Psychiatric and Substance Abuse Hospitals	$418	$253	$418	$253	$489	$319
622310	Specialty Hospitals (excl. Psychiatric, Substance)	$308	$177	$256	$172	$342	$223
623110	Nursing Care Facilities (Skilled Nursing Facilities)	$192	$129	$192	$129	$234	$153
623210	Residential Intellectual, Developmental Disability	$201	$135	$206	$138	$217	$144
623220	Residential Mental Health and Substance Abuse	$255	$171	$258	$173	$298	$196
623311	Continuing Care Retirement Communities	$145	$97	$145	$97	$171	$113
623312	Assisted Living Facilities for the Elderly	$147	$98	$156	$104	$194	$126
623990	Other Residential Care Facilities	$164	$110	$169	$113	$193	$127
624110	Child and Youth Services	$134	$90	$142	$95	$152	$101
624120	Services for Elderly and Persons with Disabilities	$121	$81	$121	$81	$136	$90
624190	Other Individual and Family Services	$134	$90	$146	$97	$150	$99
624210	Community Food Services	$175	$116	$196	$129	$177	$116
624221	Temporary Shelters	NA	NA	$173	$115	$190	$125
624229	Other Community Housing Services	$175	$116	$182	$120	$200	$131
624230	Emergency and Other Relief Services	$165	$110	$198	$130	$184	$120
624310	Vocational Rehabilitation Services	$133	$89	$136	$91	$167	$109
	Firefighter-EMT	$143	$96	$141	$95	$150	$99

Source: OSHA, 2023.

NA = no establishments

In the PIRFA, Section IV, Table 28 summarizes total training costs per facility, in year one and subsequent years, including both trainer- and trainee-related costs

ISSUES

- OSHA welcomes feedback on the potential requirements for training. What is the minimum amount of employee and manager training necessary for addressing WPV? Do you agree with OSHA's designation of different levels of training for different types of employees? If not, how should OSHA realign these groups? Are there employees who you think will need more training than OSHA is requiring? Or any that could receive less training without affecting their level of protection from WPV?

- Has OSHA included the correct topics in each category of training? Are there additional topics that should be covered or are any of the topics included in the training requirements unnecessary?

- OSHA welcomes comment on whether your facility does or would provide advanced training to some employees as OSHA has discussed above. Do you think it's important for some employees to have this advanced level of training? Alternatively, do you think all employees should receive this kind of training?

- Do you anticipate that you or others in the potentially regulated community will train employees to be able to train others in their facility. Why or why not?

- Are OSHA's estimates of the costs of outside trainers and in-house trainers accurate? Why or why not? Is there a way that OSHA could structure training requirements to reduce the costs for trainers?

- OSHA estimated that 100 percent of patient/client/resident care employees in behavioral health settings, 45 percent of residential care patient/client/resident care employees, and 20 percent of patient/client/resident care employees in other settings (hospitals, long term care, EMS, social assistance, etc.) participate in the intermediate training. Do you agree with these estimates? If not, what do you think would be more appropriate?

- Are there other categories of employers besides behavioral health and residential care that are likely to need to train more than 20 percent of their employees at the intermediate training level?

- What is the minimum level of training that should be provided for patient/client/resident contact employees on WPV prevention measures? Why?

As discussed above, OSHA has estimated a certain amount of training hours for each tier of training:

- Direct patient/client/resident contact duties - 2 hours of instruction time for employees and their immediate supervisory staff.
- Direct patient/client/resident care duties in non-high-risk services - 4 hours of instruction for employees and their supervisory staff.
- Direct patient/client/resident care duties in high-risk services - 8 hours of instruction for employees and their supervisory staff.
- Employees who are reasonably expected to respond to incidents of WPV - 24 hours of instruction for employees and their supervisory staff.

OSHA examined a scenario where the training requirements were the same but assumed that the hours of initial and supplemental instruction were previously overestimated and should instead be half of what was originally estimated.

OSHA calculated that if the amount of time necessary to train employees was less than originally estimated the costs of the potential standard would be reduced by $454.4 million, or $1,512 per facility.

OSHA additionally examined a scenario where the most extensive level of training would take no more than 8 hours to complete, rather than the original estimate of 24 hours of instruction. So, while the topics covered by the training would be different for the employees receiving this training, the time required to receive this specialized training is estimated to be the same as the time necessary for the intermediate level of training.

OSHA estimates that the costs associated with these reduced training hour expectations would amount to a reduction of $19.8 million, or $66 per facility.

- OSHA welcomes SER feedback on the training time estimates. In your experience, do you think the original training time estimates of between 2 and 24 hours were reasonable? Why or why not? Or should OSHA use different estimates for any or all categories of worker training? If so, what do you suggest? What is the basis for alternative estimates?

- Do you agree that the most extensive level of training could be completed in eight hours? If not, how much time do you think is necessary to cover the topics discussed above that would be covered by the most extensive training?

Training Alternative #1: **Remove annual training; retain initial training**

Under this alternative, employees with direct-patient/client/resident care or direct-patient/client/resident contact would complete initial training, and supplemental training as necessary. Following the initial training, these employees would only receive supplemental training whenever there are significant changes to any workplace violence-related procedures or controls or if employees demonstrate a need for refresher training.

OSHA estimates that the savings associated with removal of requirement for annual employee retraining, would amount to $755.1 million, or $2,513 per facility per year – with a percent change of annualized cost of -62.1 percent.

Training Alternative #2: **Require annual training for a more limited subset of employees (e.g., those with direct-patient/client/resident care and violent incident response duties only)**

Under this alternative, only employees with direct patient/client/resident care and violent incident response duties (e.g., emergency response teams, individual responder duties) would be required to complete training. Employers with employees who provide only direct patient/client/resident contact (i.e., physically close to patients or clients when performing duties), but not responsible for direct patient/client/resident care, would not be required to provide workplace violence prevention training for these employees. OSHA estimates that the savings associated with removal of requirement for training of direct patient/client/resident contact employees, would amount to $19.7 million, or $65.40 per facility – with a percent change of annualized cost of -1.6 percent.

Training Alternatives #3 and #3a: **Require refresher training every 3 years (triennially) or every 2 years (biennially) instead of annually**

This alternative would require employers to only provide refresher training for all tiers of employees every 3 years, instead of annually**.**

OSHA estimates that the savings associated with this alternative training timing (every three years instead of annually) would amount to $510.8 million, or $1,700 per facility – with a percent change of annualized cost of -42.0 percent.

Alternatively, if OSHA required that employers provide refresher training for all tiers of employees every two years, OSHA estimates that the savings associated with this reduced periodicity of training (every two years instead of annually) would amount to $419.7 million, or $2,081 per affected employer – with a percent change of annualized cost of -35.0 percent.

ISSUES

- OSHA requests feedback from SERs about these alternatives. Do you think training should be required annually? Why or why not?
- Is there an alternative schedule besides annually on which you think employees should be retrained on WPV prevention? If so, please specify.
- Are there types or groups of employees who should be retrained less or more frequently than annually? If so, please specify which groups and how frequently you think training needs to occur for those groups. What is the basis for your recommendations?

Training Option #1: **Require the most extensive level of training (estimated to take 24 hours) for employees at small facilities (≤2 employees on site)**

This option would require the most extensive level of training – estimated to take 24 hours – for all employees at any establishment with only one or two employees on site for example, in smaller-sized behavioral health group home. OSHA believes that frequently these employees may be instructed to call 911 to deal with issues of workplace violence, however under this option, employers would be required to provide extensive training for these employees consistent with that which would be expected for employees designated to respond to workplace violence incidents.

OSHA estimates that the cost associated with training two employees per affected facility under this training option would amount to $14.1 million, or $565.00 per affected facility – an increase in annualized cost of 1.2 percent.

Alternatively, if only one employee per facility is trained under this training option, OSHA estimates that the costs would amount to $7.0 million, or $282.50 per affected facility – an increase in annualized cost of 0.6 percent.

ISSUES

- OSHA welcomes SERs' thoughts on requiring extensive training for some groups of employees. Do you think OSHA should require some or all workers at some or all establishments should receive advanced practical training in de-escalation, chemical and physical restraints, and all standard operating procedures of the response team? Why or why not?

- If you think this should be required, at which type of establishments should OSHA require this type of training and how many employees at those establishments should receive this training?

(g) Violent Incident Investigation and Recordkeeping and (h) Retention of Records

Section (g) of the draft regulatory framework has several requirements regarding violent incident reporting and maintenance of related records. Section (h) of the draft regulatory framework includes requirements for record retention. Specifically:[4]

Violent incident investigation. Under the draft regulatory framework, employers must investigate the circumstances of each reported WPV incident within 24 hours of the incident occurring and document the significant contributing factors, recommendations, and any corrective measures that will be taken to prevent similar incidents.

Violent incident log. Under the draft regulatory framework, employers must implement and maintain a violent incident reporting system, with an emphasis on encouraging employees to report each violent incident that occurs in the workplace and soliciting input from the employee(s) who experienced or observed the workplace violence. The violent incident log must include key information such as the nature and extent of the employee's injuries; the date, time, and location of the incident; the job titles of involved employee(s); a description of circumstances at the time of the incident; and a classification of the person who committed the violence (e.g., patient, coworker, stranger, etc.)

Retention of records. Under the draft regulatory framework, employers must maintain records from WVPP development, hazard assessment and control processes, and incident investigations for at least three years. In addition, training records must be maintained for at least one year.

The labor burden and cost per facility presented here will be constant each year, assuming the same number of incidents occur each year. OSHA's estimated costs for these elements may be overestimated if regulatory framework decreases the number of WPV incidents.

Incident investigation costs are a function of the estimated number of incidents per facility, and the labor burden for investigating different types of incidents.

[4] Costs for investigation procedures are included as part of the costs for the WVPP in section (c). Incident-related hazard assessment costs are accounted for in the costs for hazard assessments in section (d).

OSHA estimated the number of incidents per facility per year based on BLS data on workplace violence incidents. These data are summarized in Table 14 in the PIRFA, and detailed data summarizing incidents *by incident type* (i.e., lost-work, non-lost-work, other physical, and credible threats) are reported in Appendix C in the PIRFA.

The amount of time for an investigation of a violent incident, in the agency's judgment, varies by type (severity) of incident but not by type or size of facility. OSHA allocated total labor burden to a mix of management and patient/client/resident contact/care occupation categories, reflecting their joint participation in the process.

Table 15 presents OSHA's estimate of the per-incident labor burden, by incident type and labor category, for incident investigations.

Table 156 Incident Investigation Labor Burden per Incident

Type of WPV Incident and Labor Category	Investigation Hours
Lost Work Incidents	
Patient or Client Care/Contact Employee	2
Management/Supervisor Employee	4
Non-Lost Work Incidents	
Patient or Client Care/Contact Employee	1.5
Management/Supervisor Employee	3
Other Physical	
Patient or Client Care/Contact Employee	1
Management/Supervisor Employee	2
Threats	
Patient or Client Care/Contact Employee	0.5
Management/Supervisor Employee	1

Source: OSHA, 2023.

OSHA estimated total labor burden per facility by taking the product of the number of incidents by type and the associated investigation labor assumptions above; this burden was then monetized using manager and employee wages.

Table 16 summarizes per-facility costs for incident investigation.

Table 167 Incident Investigation Burden and Cost per Facility, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621112	Offices of Physicians, Mental Health Specialists	0.6	$50	0.0	$1	0.0	$1
621330	Offices of Mental Health Practitioners	1.2	$89	0.1	$5	0.0	$3
621420	Outpatient Mental Health and Substance Abuse	1.0	$64	0.5	$29	0.1	$7
621493	Freestanding Ambulatory Surgical, Emergency	0.6	$44	0.3	$24	0.2	$11
621610	Home Health Care Services	0.8	0.8	0.3	$0	0.0	$0
621910	Ambulance Services	0.8	0.8	0.5	$0	0.1	$0
622110	General Medical and Surgical Hospitals	107.2	$8,730	13.9	$1,133	0.2	$19
622210	Psychiatric and Substance Abuse Hospitals	484.2	$34,765	92.2	$6,620	5.0	$360
622310	Specialty Hospitals (excl. Psychiatric, Substance)	47.7	$3,908	6.9	$567	0.3	$29
623110	Nursing Care Facilities (Skilled Nursing Facilities)	7.6	$451	4.8	$286	0.3	$16
623210	Residential Intellectual, Developmental Disability	10.6	$372	3.3	$115	2.4	$84
623220	Residential Mental Health and Substance Abuse	14.2	$712	4.6	$229	1.6	$79
623311	Continuing Care Retirement Communities	5.7	$275	2.4	$118	0.3	$13
623312	Assisted Living Facilities for the Elderly	2.1	$103	0.6	$29	0.2	$11
623990	Other Residential Care Facilities	43.0	$1,856	6.6	$283	3.6	$155
624110	Child and Youth Services	16.6	$17	1.7	$2	1.1	$1
624120	Services for Elderly and Persons with Disabilities	4.8	$5	1.0	$1	0.2	$0
624190	Other Individual and Family Services	4.2	$4	0.3	$0	0.2	$0
624210	Community Food Services	0.4	$0	0.2	$0	0.1	$0
624221	Temporary Shelters	NA	NA	0.8	$1	0.3	$0
624229	Other Community Housing Services	0.8	$1	0.5	$0	0.2	$0
624230	Emergency and Other Relief Services	1.2	$1	0.2	$0	0.1	$0
624310	Vocational Rehabilitation Services	5.3	$5	1.9	$2	0.4	$0
	Firefighter-EMTs	4.5	$270	0.5	$28	0.2	$14

Source: OSHA, 2023.

As with investigations, per-incident and facility costs for creation of the incident log are a function of the estimated number of incidents per facility, by incident type, and an estimated labor burden per type of incident. OSHA estimates that reportable lost-work and non-lost-work incidents require 10 minutes per incident to create a log entry, while less severe incidents (other physical and threat incidents) require 5 minutes. A log entry is assumed to be created by a manager.

For employer maintenance of records for all hazard assessment and incident investigations, OSHA estimated a per-record labor burden of 5 minutes (0.08 hours) per

year. Estimated annual labor burden per facility for record retention was monetized using clerical wages.

Table 17 summarizes facility costs for recordkeeping (i.e., incident log creation and records retention).

Table 17 Recordkeeping Burden and Cost per Facility, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621112	Offices of Physicians, Mental Health Specialists	0.04	$1.08	0.00	$0.02	0.00	$0.02
621330	Offices of Mental Health Practitioners	0.08	$2.19	0.00*	$0.12	0.00*	$0.06
621420	Outpatient Mental Health and Substance Abuse	0.07	$1.93	0.03	$0.88	0.01	$0.23
621493	Freestanding Ambulatory Surgical, Emergency	0.04	$1.23	0.02	$0.68	0.01	$0.31
621610	Home Health Care Services	0.8	0.8	0.27	$0.27	0.05	$0.05
621910	Ambulance Services	0.8	0.8	0.46	$0.46	0.15	$0.15
622110	General Medical and Surgical Hospitals	7.08	$207.00	0.92	$26.87	0.02	$0.45
622210	Psychiatric and Substance Abuse Hospitals	31.44	$955.16	5.99	$181.87	0.33	$9.90
622310	Specialty Hospitals (excl. Psychiatric, Substance)	3.11	$92.14	0.45	$13.37	0.02	$0.67
623110	Nursing Care Facilities (Skilled Nursing Facilities)	0.50	$14.62	0.32	$9.28	0.02	$0.52
623210	Residential Intellectual, Developmental Disability	0.70	$20.27	0.21	$6.25	0.16	$4.57
623220	Residential Mental Health and Substance Abuse	0.93	$27.82	0.30	$8.96	0.10	$3.10
623311	Continuing Care Retirement Communities	0.37	$10.95	0.16	$4.71	0.02	$0.50
623312	Assisted Living Facilities for the Elderly	0.14	$4.12	0.04	$1.17	0.01	$0.42
623990	Other Residential Care Facilities	2.80	$82.10	0.43	$12.54	0.23	$6.88
624110	Child and Youth Services	16.61	$16.61	1.67	$1.67	1.14	$1.14
624120	Services for Elderly and Persons with Disabilities	4.76	$4.76	0.98	$0.98	0.19	$0.19
624190	Other Individual and Family Services	4.19	$4.19	0.33	$0.33	0.21	$0.21
624210	Community Food Services	0.43	$0.43	0.24	$0.24	0.13	$0.13
624221	Temporary Shelters	NA	NA	0.76	$0.76	0.29	$0.29
624229	Other Community Housing Services	0.80	$0.80	0.49	$0.49	0.23	$0.23
624230	Emergency and Other Relief Services	1.22	$1.22	0.23	$0.23	0.12	$0.12
624310	Vocational Rehabilitation Services	5.30	$5.30	1.91	$1.91	0.36	$0.36
	Firefighter-EMTs	0.29	$8.15	0.03	$0.84	0.01	$0.42

Source: OSHA, 2023.

* = appears as zero due to rounding.

ISSUES

- OSHA welcomes comments on the potential violent incident investigation and recordkeeping requirements. Is a violent incident log a useful tool for understanding and mitigating WPV hazards? Why or why not?

- Are there obstacles to investigating within 24 hours? If so, what alternative time frame for the investigation do you recommend and why?
- OSHA's draft regulatory framework states that the violent incident log should include, among other things, the nature and extent of the employee's injuries; the date, time, and location of the incident; the job titles of involved employee(s); a description of circumstances at the time of the incident; and a classification of the person who committed the violence (e.g., patient, coworker, stranger, etc.). Do you agree that these are the necessary and appropriate details to include in a log? If not, which do you think should be eliminate? Should any be added?
- Do OSHA's estimates of incident frequency and investigation time line up with your experiences? If not, please provide details on how OSHA should adjust these estimates.
- Are OSHA's assumptions about costs for recordkeeping and retention of records reasonable?

Violent Incident Investigation and Recordkeeping Alternative #1: **Requirement for post-incident investigations only for workplace violence incidents involving physical assault**

This alternative would require a post-incident investigation only if the workplace violence incident involved a physical assault. Under this alternative, verbally or physically threatening behavior would not necessitate a post-incident investigation. OSHA understands that given the nature of some healthcare and social assistance services covered within several sectors in the scope of this regulatory framework, there may regularly be patients or clients who issue verbal or present physical threats due to emergent health conditions and/or mental health crises, and it may be challenging and time-consuming for employers to investigate every threat. OSHA also acknowledges that the most pressing type of incident to investigate are those that involve physical assault. By limiting investigations to incidents of physical assault, employers may be able to focus on the highest-risk incidents.

OSHA also invites comment from SERs on an expansion to this Recordkeeping Alternative #1 that would only require a post-incident investigation if the workplace violence incident involved care beyond first aid. For example, if the employee does not require any care (e.g., minor scratches/bruising), no investigation would need to be conducted by the employer. OSHA understands that, given the nature of some of the healthcare and social assistance services covered within several sectors in the scope of this draft standard, there may be patients or clients who behave in manners that may be unintentionally harm employees. OSHA estimates that the savings associated with this

violent incident investigation alternative would amount to $13.7 million – with a percent change of annualized cost of -1.1 percent.

ISSUES

- OSHA welcomes SERs' thoughts on these alternatives. Should OSHA require incident investigation for only incidents that either involve physical assault or require medical care beyond first aid? Why or why not?
- Is there an alternate distinction OSHA should make on which incidents should be subject to incident investigations? If so, please explain.

Provision of Post-Incident Medical Treatment and Mental Health Evaluations Option #1: **Employers would be required to offer and provide post-incident medical treatment and mental health evaluations for employees who have experienced workplace violence incidents that result in injuries requiring treatment beyond first aid.**

Under this option, employers would provide post-incident medical and mental health evaluations and treatment for the affected employee for a period not to exceed one year, at no cost to the employee. Time associated with an employee needing to receive post-incident medical and mental health evaluations/treatment, and reasonable travel time (as appropriate) would be considered compensable time. OSHA has assumed one hour of evaluation per week for one year, with $5 of travel time per session.

For WPV recordable, lost-workday incidents, the costs of post-incident medical treatment and/or mental health evaluations will total $108.7 million ($539 per affected employer), raising total costs for the WPV draft regulatory framework to $1.32 billion.

For WPV recordable non-lost-workday incidents, the costs of post-incident medical treatment and/or mental health evaluations will total $231.6 million ($1,148 per affected employer or $2,200 per-employee), raising total costs for the WPV regulatory framework to $1.45 billion. The per-employee costs assumes that all affected employees would use one full year of weekly counseling. OSHA suspects this may be a significant over-estimate.

ISSUES

- Do you think OSHA should require post-incident medical treatment? Why or why not?
- Do you think OSHA should require post-incident mental health treatment? Why or why not?

- What concerns, if any, would you have about OSHA including such a requirement for either medical treatment or mental health treatment, or both?
- What benefits would mental health treatment provide to worker health and to you as an employer? Do employees typically receive time off from work following a WPV incident? Is it common for employees to exhibit signs or symptoms of mental health problems (depression, irritability, absence from work, etc.) following a WPV incident? Are you aware of instances where employees have left their jobs or requested a transfer to a different location or job duty following a WPV incident?
- What type of post-incident medical treatment and/or mental health evaluations and treatment are typically available to workers? Do entities that provide these types of treatment programs typically experience more or less job turnover in affected job positions than entities that do not provide these programs?
- If you have implemented post-incident medical and/or mental health evaluations and treatment, OSHA would be interested to hear your experiences. How do these services work? What has been the cost associated with these programs? Have you seen a benefit to your workers?

Security Staffing Issues

OSHA recognizes that many employers have different operational models and that the role of security personnel may exist to varying degrees or may largely be absent altogether.

- In the PIRFA, security staff have been classified as patient/client/resident contact employees. Is this an accurate categorization? Should security staff (when available in covered establishments) be classified as patient/client/resident care staff? Should security staff be considered as a separate category altogether?
- What is the current role of security personnel in the management of workplace violence incidents? Are they responsible for physically responding to WPV incidents, or are they primarily responsible for observing and reporting to police or other authorities? What role does security personnel serve with respect to workplace violence recordkeeping and incident investigation at your facility?
- Does each entity typically have dedicated security personnel, or are some employees with other responsibilities also tasked with providing security? Are designated security personnel typically contracted from a security firm, or direct employees of the entity providing health or social services?

- What kind of training do security personnel receive in order to manage these situations? If the security personnel are employees of a contractor, who provides their training? The contractor, the health or social services provider, or both?
- Should security personnel be covered under OSHA's contemplated training requirements? Or would it be more appropriate for OSHA to treat security personnel as if they are already receiving sufficient training and equipment to protect *themselves* during WPV incidents such that OSHA's standard should be focused on the involvement of security in protecting other workers (e.g., ensuring that security personnel are trained to coordinate with other employees as part of a WVPP)?

Other General Issues

OSHA is interested to receive input from SERs as to whether any of the potential requirements discussed in this Issues Paper or the PIRFA run directly counter to the ethos or operational model of any represented establishments, or whether any SERs have concerns that compliance with a potential requirement or requirements could not be technologically feasible. OSHA also recognizes that there may be some language in the provided draft regulatory framework that may not be directly applicable to the operations of some industry sectors within the contemplated scope (and particularly with regard to some sectors within social assistance services) and seeks input from SERs in helping identify such language.

OSHA also welcomes thoughts, feedback, and additional data on the effectiveness of WPV prevention programs. Are there specific controls you have found to be especially useful in preventing or reducing WPV incidents?

If you have implemented a WPV prevention program in your facility, what effect has that had? Have you seen a reduction in the number of WPV incidents or the number of injuries sustained by workers due to WPV incidents? Have you seen a reduction in the severity of incidents?

OSHA is especially interested in any data or studies you have or know of that evaluate the effectiveness of WPV prevention programs.

Appendix A. Costs for Regulatory Alternatives

Table A-1. Annualized Costs for Regulatory Alternatives ($2019)

Regulatory Alternative	Change in Annualized Cost ($M) (3%)	Percent Change in Annualized Cost	Annualized Cost, Alternative (3%)
Scope: General and/or Multiple Sections Affected			
1. Standard applies to "patient/client/resident care" only – not "patient/client/resident contact"; Remove patient/client/resident contact employees (Scope Alternative #1)	($23,516,110)	-1.9%	$1,192,336,875
2. Only include NAICS 6241, Individual and Family Services, in the Social Assistance Setting (Scope Alternative #2)	($23,997,530)	-1.97%	$1,191,855,456
3. Elimination of non-fixed location sectors from the standard (Emergency Response, Field-based Healthcare & Social Assistance Services) (Scope Alternative #3)	($285,391,219)	-23.47%	$930,461,766
4. Expand scope to include locations where healthcare services are provided in correctional facilities and educational settings. (Scope Option #1)	$124,129,795	10.21%	$1,339,982,780
C. WVPP			
5. Staggered periodicity of annual review (biennially, triennially vs. annually) (estimate shown is the biennial alternative) (WVPP Alternative #1)	($22,037,560)	-1.8%	$1,193,815,425

Table A-1, continued. Annualized Costs for Regulatory Alternatives ($2019)

Regulatory Alternative	Change in Annualized Cost ($M) (3%)	Percent Change in Annualized Cost	Annualized Cost, Alternative (3%)
D. Hazard Assessment			
6. Reduce magnitude / size of records review for annual hazard assessments to 1 year or 2 years of records (estimate shown is for the 1-year alternative) (Hazard Assessment Alternative #1)	($5,663,316)	-0.47%	$1,210,189,669
7. Employers would only assess OSHA-defined high-risk service areas and not be expected to identify additional high-risk services areas based on their experiences and recordkeeping (Hazard Assessment Alternative #2)	($49,264,063)	-4.05%	$1,166,588,922
8. Change the definition of high-risk service area -- No requirement for employers to conduct establishment-wide hazard assessments based on OSHA's pre-determinations of high-risk service areas; hazard assessments would be directed to employer-defined high-risk service areas assessments only (Hazard Assessment Alternative #3)	($157,322,225)	-12.94%	$1,058,530,760
E. Hazard Controls			
9. Removal of requirement for employers to make modifications/fix problems; Require only hazard assessment, development of a plan, and provision of training (Hazard Controls Alternative #1)	($101,667,773)	-8.36%	$1,114,185,212
10. Remove requirement for all employers to implement environmental or engineering controls; Require that employers implement administrative/work-practice controls only -- No requirement for employers to implement environmental or engineering controls (Hazard Controls Alternative #1a)	($93,996,083)	-7.73%	$1,121,856,902
11. Remove requirement for all employers to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #2)	($9,965,590)	-0.82%	$1,205,887,395
12. Remove requirement for small entities to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #3)	($1,047,187)	-0.09%	$1,214,805,798
F. Training			
13. Remove annual training; retain initial training (Training Alternative #1)	($755,090,859)	-62.10%	$460,762,126

Table A-1, continued. Annualized Costs for Regulatory Alternatives ($2019)

Regulatory Alternative	Change in Annualized Cost ($M) (3%)	Percent Change in Annualized Cost	Annualized Cost, Alternative (3%)
14. Require training for a more limited subset of employees (Training Alternative #2)	($19,650,597)	-1.62%	$1,196,202,388
15. Reduce the expected number of training hours (Training Alternative #3)	($454,405,330)	-37.4%	$761,447,655
16. Require refresher training every 3 years instead of annually (Training Alternative #3)	($510,796,039)	-42.01%	$705,056,946
16a. Require refresher training every 2 years instead of annually (Training Alternative #3a)	($419,738,961)	-34.5%	$796,114,024
17. Require 24 hours of training for small facilities (≤2 employees on site) (Training Option #1)	$14,139,424	1.16%	$1,229,992,409
18. Reduction of expectation of training length for the most advanced level of employee workplace violence prevention training (Training Sensitivity Test #1)	($19,848,474)	-1.6%	$1,196,004,511
G. Violent Incident Investigation & Recordkeeping			
19. Require post-incident investigations only for workplace violence incidents involving physical assault (Incident Investigation Alternative #1)	($13,729,830)	-1.13%	$1,202,123,156
20. Post-incident medical and psychological evaluations and treatment			
WPV Recordable, Lost-Work Incidents Post-incident Evaluations Options #1)	$108,746,045	8.90%	$1,324,599,030
WPV Recordable, Non-Lost-Work Incidents (Post-incident Evaluations Options #2)	$231,641,450	19.10%	$1,447,494,435
Total Recordable WPV Incidents Post-incident Evaluations Options #3)	$340,387,495	28.00%	$1,556,240,480
21. Effective Date of the Standard Alternative: Extension of compliance date for requirements in paragraphs (e) Control Measures and (f) Training or any other provisions in this draft standard might require more than six months to come into compliance.			
22. General Alternative: OSHA opts to take no action on this draft standard on Prevention of Workplace Violence in Healthcare and Social Assistance, and			

Table A-1, continued. Annualized Costs for Regulatory Alternatives ($2019)

Regulatory Alternative	Change in Annualized Cost ($M) (3%)	Percent Change in Annualized Cost	Annualized Cost, Alternative (3%)
continues to address workplace violence hazards in healthcare and social assistance solely through use of the General Duty Clause.			

Source: OSHA, 2023.

Section I. Introduction

The SBREFA Process for Prevention of Workplace Violence in Healthcare and Social Assistance

Workplace violence against employees in the healthcare and social assistance sector is a serious concern. As discussed below, evidence indicates that employees in this sector face a substantially increased risk of injury due to workplace violence. The Department intends to initiate the Small Business Regulatory Enforcement Fairness Act (SBREFA) process as the agency considers promulgating a new Workplace Violence standard to protect healthcare and social assistance workers from workplace violence.

The standard would help ensure that covered employers take the necessary steps to protect employees from workplace violence and are appropriately prepared for emergency incidents. This draft standard, called Prevention of Workplace Violence in Healthcare and Social Assistance, would cover workers in healthcare and social assistance sectors with heightened risk of State Plan [1] regulations. Many entities providing healthcare and social assistance services (primarily state, county, and municipal government employers not covered by a State Plan) do not fall under OSHA's jurisdiction.

Background

In March 2016, the U.S. Government Accountability Office (GAO) issued a report summarizing its investigation of OSHA's efforts to protect healthcare workers from workplace violence.[2] The GAO Report made a number of recommendations to the agency, including considering whether additional action, such as developing a workplace violence standard, is necessary. Labor organizations representing healthcare workers petitioned OSHA for a workplace violence prevention standard several months later, and the agency published a request for information (RFI) related to the two petitions in December 2016. *See* 81 Fed. Reg. 88147 (Dec. 7, 2016). OSHA granted the rulemaking petitions in January 2017.

Regulatory Framework

OSHA is proposing a regulatory framework to cover the following employers:

[1] Under section 18 of the OSH Act, states may assume responsibility for the development and enforcement of occupational safety and health standards if they receive federal approval of their State Plan. State Plans must be at least as effective as the federal OSHA program and must also cover state and local government employees. *See* 29 U.S.C. § 667.

[2] GAO, Workplace Safety and Health: Additional Efforts Needed to Help Protect Healthcare Workers from Workplace Violence, 2016; https://www.gao.gov/assets/680/675858.pdf.

(a) Hospitals, including emergency departments;
(b) Psychiatric hospitals and residential behavioral health facilities;
(c) Ambulatory mental healthcare and ambulatory substance abuse treatment centers;
(d) Freestanding emergency centers;
(e) Residential care facilities;
(f) Home healthcare;
(g) Emergency medical services; and
(h) Social assistance (excluding child day care centers).

OSHA has also provided multiple regulatory alternatives covering specific sectors within this scope for consideration. Any rule that OSHA may propose would emphasize recognized and consistent controls and work practices with the goal of protecting workers covered by the rule. The draft rule could include requirements for covered employers to conduct worksite hazard assessments, develop and implement an effective written workplace violence prevention plan, and implement controls to reduce workplace violence.

OSHA's draft standard uses a programmatic, performance-based approach with a series of provisions that would require employers to develop and implement workplace violence prevention. Employers would be required to perform regular hazard assessments based on their own injury records as well as identify and mitigate hazards in the work environment and hazards associated with work practices. OSHA believes this approach would provide more flexibility with decreased training requirements, and more flexibility in the required engineering and administrative controls for establishments with lower rates of WPV. Employers would have flexibility to tailor the plan and its implementation to specific workplace conditions and hazards. OSHA believes that a rule as outlined in the regulatory framework would have the direct benefit of reducing injuries from workplace violence among covered workers, but it has not yet attempted to quantify that benefit.

SBREFA process

As noted earlier, OSHA has developed a regulatory framework for a workplace violence prevention rule that demonstrates OSHA's current thinking on the provisions that a proposed rule could include. The next step in OSHA's regulatory process is consulting with small businesses pursuant to the SBREFA. Small entities, under the Regulatory Flexibility Act (RFA), include small businesses, small not-for-profit enterprises, and small government jurisdictions. For purposes of defining small businesses, OSHA uses the industry-specific size standard published by SBA (for more information, visit https://www.sba.gov/content/summary-size-standards-industry-sector).

The SBREFA process begins when DOL notifies the Small Business Administration (SBA) Office of Advocacy of its intent to initiate the SBREFA. In accordance with the RFA (Sections

601 through 612 of Title 5 of the United States Code), OSHA is convening a Small Business Advocacy Review Panel (SBAR Panel). This Panel consists of representatives from OSHA, SBA's Office of Advocacy, and the Office of Information and Regulatory Affairs (OIRA) in the Office of Management and Budget (OMB). The SBAR Panel identifies individuals who are representatives of affected small entities, termed Small Entity Representatives (SERs). Traditionally, OSHA has provided individual SERs with a draft regulatory framework, a description of possible regulatory alternatives, and any cost estimates that OSHA has compiled for the range of alternatives. This information becomes available publicly when it is given to the SERs.

The SBAR Panel has several purposes. First, the Panel provides an opportunity for affected small employers, the SBA's Office of Advocacy, and OIRA to provide comments to OSHA. Second, by reviewing OSHA's potential regulatory framework for a workplace violence standard and estimates of the potential impacts of that rule, SERs and the Panel can offer recommendations to OSHA on ways to tailor the rule to make it more cost-effective and less burdensome for affected small entities. Third, early comments permit identification of different regulatory alternatives the agency might consider. Finally, the SBAR Panel report can provide specific recommendations for OSHA to consider on issues such as reporting requirements, timetables of compliance, and whether some groups -- including small entities -- should be partially or entirely exempt from any proposed rule.

Following the SBAR Panel, if the agency were to move forward with rulemaking, OSHA's next step would be to publicly propose the new rule in the Federal Register. The Preamble to the proposed rule would include an Initial Regulatory Flexibility Analysis (IRFA) to focus attention on the potential impacts on small entities. The IRFA would include a description of the Panel's recommendations and OSHA's responses to those recommendations. Sections 603(b) and (c) of the RFA set out the requirements for the IRFA:

(b)(1) a description of the reasons why action by the agency is being considered;

(b)(2) a succinct statement of the objectives of, and legal basis for, the proposed rule;

(b)(3) a description of and, where feasible, an estimate of the number of small entities to which the proposed rule will apply;

(b)(4) a description of the proposed reporting, recordkeeping, and other compliance requirements of the proposed rule, including an estimate of the classes of small entities that will be subject to the requirements and the type of professional skills necessary for preparation of the report or record;

(b)(5) an identification, to the extent practicable, of all relevant federal rules that may duplicate, overlap, or conflict with the proposed rule; and

(c) a description of any significant alternatives to the proposed rule that accomplish the stated objectives of applicable statutes that minimize any significant economic impact of the proposed rule on small entities.

An alternative under Section 603(c) need not be unique to small entities. Rather, an alternative that meets OSHA's goals and reduces impacts for all affected entities can, and should be, considered as part of the Panel and regulatory flexibility analysis process.

Under Section 609(b) of the RFA, the SBAR Panel must be provided any information that OSHA has available on issues related to paragraphs (3), (4), and (5) of Section 603(b), as well as Section 603(c), of the RFA. The SBAR Panel collects comments on these issues.

This preliminary IRFA (PIRFA) document provides the information required under Section 609(b) of the RFA to the members of the SBAR Panel and to individual SERs who have agreed to participate in this SBAR Panel. The PIRFA document also satisfies the RFA's legal requirement that OSHA provide certain information to the Chief Counsel for Advocacy. OSHA has placed all references in this document in the public docket, OSHA-2016-0014 (72 Fed. Reg. 88147, Dec. 7, 2016), and is available to help SERs obtain any references they would like to see. All non-copyrighted references will be available online at regulations.gov in the docket for this potential rulemaking. Copyrighted materials are available for inspection through OSHA's docket office.

This PIRFA has been prepared to facilitate the SBAR Panel process. In addition to this introductory section, the SER Background Document contains the following sections:

Section II (p. 6) describes the legal requirements OSHA must meet if it engages in rulemaking;
Section III (p. 8) discusses the reasons why action is being considered by OSHA;
Section IV (p. 32) summarizes and explains the important provisions of OSHA's regulatory framework;
Section V (p. 88) identifies the types of small entities that would likely be affected by a rule as outlined in the regulatory framework and provides information on the potential impacts of a rule as outlined in the regulatory framework;
Section VI (p. 206) provides a review of any potentially conflicting and duplicative regulations;
Section VII (p. 213) presents, for consideration by the SERs and the Panel, alternatives and/or options to the scope of, and provisions in, the regulatory framework.

Some of the most valuable contributions SERs make in the SBAR Panel process are their comments on the alternatives and/or options presented and their suggestions for other possible alternatives.

Section II. Legal Requirements OSHA Must Meet if It Engages in Rulemaking

Congress enacted the OSH Act in 1970 "to assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources." 29 U.S.C. § 651(b). The Secretary of Labor promulgates and enforces occupational safety and health standards under authority granted by the OSH Act. *See* 29 U.S.C. 651 *et seq*. OSHA must promulgate its standards by following specific procedures set forth in the OSH Act. *See* 29 U.S.C. § 655.

Section 3(8) of the OSH Act defines an "occupational safety and health standard" as "a standard which requires conditions, or the adoption or use of one or more practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment." 29 U.S.C. 652(8). A standard is "reasonably necessary or appropriate" within the meaning of section 3(8) if it: (1) substantially reduces or eliminates a significant risk of material impairment to worker health, safety, or functional capacity; (2) is technologically and economically feasible; (3) is cost effective; (4) is consistent with prior agency action or supported by a reasoned justification for departing from prior agency action; (5) is supported by substantial evidence; and (6) must effectuate the Act's objectives better than any applicable national consensus standard. 58 Fed. Reg. 16612, 16614 (Mar. 30, 1993); *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. OSHA*, 37 F.3d 665, 668-69 (D.C. Cir 1994). To fulfill the congressional purpose underlying the Act, OSH Act standards must be highly protective. 58 Fed. Reg. at 16614–15.

The agency has discretion to "determine, in the first instance, what it considers to be a 'significant' risk," and in making this determination, the appropriate question is whether "a reasonable person might . . . take appropriate steps to decrease or eliminate it." *Industrial Union Dep't, AFL–CIO v. Marshall*, 448 U.S. 607, 655 (1980) ("*Benzene*") (plurality opinion). As such, the risk requirement is "not a mathematical straitjacket" and OSHA "has no duty to calculate the exact probability of harm." *Id.*; *see also Am. Dental Ass'n v. Martin*, 984 F.2d 823, 827 (7th Cir. 1993) (OSHA not required to quantify risk in order to establish the existence of significant risk).

Courts recognize that a determination of what constitutes significant risk will be "based largely on policy considerations." *Benzene*, 448 at 655 n.62. OSHA "is not required to support its finding that a significant risk exists with anything approaching scientific certainty [,]" and "is free to use conservative assumptions" and "risk [] error on the side of overprotection rather than under protection." *Id*. at 656; *see also Public Citizen Health Research Group v. Tyson*, 796 F.2d 1479, 1486 (D.C. Cir. 1986) ("*Ethylene Oxide*"). It is sufficient for OSHA to make a general finding of significant risk; the agency is not required to assess relative risk or disaggregate its significant risk analyses by hazard, workplace, or industry. *See, e.g., UAW v. OSHA*, 37 F.3d

665, 670 (D.C. Cir. 1994) ("*Lockout/Tagout II*") (upholding OSHA's decision not to conduct individual significant risk analyses for various affected industries); *American Dental Ass'n*, 984 F.2d at 827 (OSHA is not required to evaluate risk "workplace by workplace"); *Associated Builders & Contractors, Inc. v. OSHA*, 862 F.2d 63, 68 (3d Cir. 1988) (noting that "the significant risk requirement must of necessity be satisfied by a general finding concerning all potentially covered industries"); *Ethylene Oxide*, 796 F.2d at 1502 n. 16 (rejecting the argument that the Secretary must find that each and every aspect of its standard eliminates a significant risk).

OSHA standards must be both technologically and economically feasible. *See United Steelworkers v. Marshall*, 647 F.2d 1189, 1264 (D.C. Cir. 1980) ("*Lead I*"). The Supreme Court has defined technological feasibility as "capable of being done." *Am. Textile Mfrs. Inst. v. Donovan*, 452 U.S. 490, 508-509 (1981) ("*Cotton Dust*"). OSHA demonstrates that a standard is technologically feasible if the protective measures it requires already exist, can be brought into existence with available technology, or can be created with technology that can reasonably be expected to be developed. *See American Iron and Steel Inst. v. OSHA*, 939 F.2d 975, 980 (D.C. Cir. 1991) (per curiam) (internal citation omitted). In determining the economic feasibility of a standard, OSHA must consider the cost of compliance on an industry, rather than on individual employers. A standard must not threaten "massive dislocation" to … or imperil the existence of" an industry. *See Lead I*, 647 F.2d at 1265 (internal citations omitted). The "practical question" in an economic feasibility analysis "is whether the standard threatens the competitive stability of an industry . . . or whether any intra-industry or inter-industry discrimination in the standard might wreck such stability or lead to undue concentration." *Id.* .

Section III. Reasons Why Action is Being Considered by OSHA

Overview

This draft proposal for a potential standard on prevention of workplace violence in healthcare and social assistance is based on many years of agency research, interagency engagement, and trends in workplace violence incidents as observed through OSHA enforcement of the General Duty Clause. The Healthcare and Social Assistance sector (NAICS 62) is comprised of 20.9 million employees and in recent years has grown into a major component of the U.S. economy. (U.S. Census Bureau, 2021). This industry employs diverse professionals providing healthcare and social assistance services in a variety of settings.

Healthcare and social assistance workers, including those that work in facilities providing emergency, behavioral, mental health, memory care, and social assistance services, face a significant risk of job-related violence. These workers face an increased risk of workplace violence resulting primarily from violent behavior of their patients, clients, residents, and/or visitors in their workplaces. OSHA's current non-mandatory guidance is inadequate to substantially reduce these employees' risk of workplace violence, and the agency believes the measures in this draft proposal would considerably reduce these employees' risk of workplace violence.

Data Indicate Workers in Healthcare and Social Assistance Have Substantially Increased Risk of Injury Due to Workplace Violence

Workplace violence against employees in the healthcare and social assistance industries is a serious concern. In 2019, the rate of intentional nonfatal workplace violence incidents that required the worker to take time off was significantly higher in healthcare than in private industry overall.[3] Data from the BLS Survey of Occupational Injuries and Illnesses (SOII) for

[3] The Bureau of Labor Statistics (BLS) released its Survey of Occupational Injuries and Illnesses (SOII) for 2020 in mid-November 2021. BLS publication schedules indicate that newer data will not be available in the near future. However, because 2020 was such an atypical year for the healthcare industry due to the COVID-19 pandemic, and because there was insufficient time for OSHA to conduct a thorough analysis of the recently-released 2020 data in advance of this SBREFA Panel, this section primarily presents injury data associated with "intentional injury by other person" from 2019. In general, the reported rates from BLS attributed to intentional workplace violence in the SOII increased in 2020, and OSHA has footnoted some of the 2020 data while discussing 2019 data, for SERs to reference. OSHA also presents some injury data that falls within BLS's classification "injury by person-unintentional or intent unknown." Within that category, data categorized as "restraining-subduing-unintentional" falls within OSHA's definition of workplace violence for this proposed standard because it includes injuries while restraining or subduing patients or clients. OSHA did not include, however, other data in the "injury by person-unintentional or intent unknown" category, because some of these injuries fall outside OSHA's definition of workplace violence. Note that this data encompasses workplace violence only in BLS-designated "private industry"; it does not encompass workplace violence incidents in other facilities such as government-operated facilities. The rates of violent incidents is generally higher in those other facilities, but many of those would not be subject to OSHA standards.

2019 show that the average rate of workplace violence incidents for all industries is estimated at a lost-workday incidence rate of 2.0 per 10,000 employees per year.[4]

By comparison, healthcare and social assistance workers experienced a rate of violence nearly six times that, with workplace-violence-related injuries at an estimated lost-workday incidence rate of 11.7 per 10,000 full-time workers per year (9.7 intentional injury by another person and 2.0 unintentional injury while restraining or subduing)[5]– with a total of 16,450[6] nonfatal injuries in 2019 alone. For certain segments of the healthcare and social assistance industry, the injury rate is even higher, such as in psychiatric and substance abuse hospitals, which had 146.5 injuries per 10,000[7] full-time workers per year (107.5 intentional injury by another person and 39.0 unintentional injury while restraining or subduing), and residential intellectual and developmental disability, mental health, and substance abuse facilities, which had 55.6 injuries per 10,000[8] full-time workers per year (44.4 intentional injury by another person and 11.2 unintentional injury while restraining or subduing) (BLS, 2019, R-4, R-8, and Special Run for Intentional vs. Unintentional 2019-2020).

Additional data pertaining to nonfatal workplace violence incidents severe enough to cause days away from work are presented in Figure-1. Note that these injuries can be significant and often require many days away from work -- ranging from 1 to 180 days. The average of the median number of days away from work for each injury is 14 days. (BLS Special Run Data - Number, median days away from work and relative standard errors of occupational injuries and illnesses involving days away from work 3 in health care and social assistance from violence by industry, occupation, and source for All United States, 2019)

Figure-1 lists the number and rate of workplace violence injuries for each sector in OSHA's contemplated scope. Not listed in Figure-1 (but included in OSHA's draft scope) are freestanding emergency centers and firefighters cross-trained in EMS for which OSHA does not have equivalent data at this time.

[4] BLS data for 2020 "all industries" is a rate of 2.1 per 10,000 full-time workers per year.
[5] BLS data for 2020 "healthcare and social assistance" is a rate of 17.3 injuries per 10,000 full-time workers per year (10.3 intentional injury by another person and 0.7 unintentional injury while restraining or subduing).
[6] BLS data for 2020 "healthcare and social assistance" is 15,210 non-fatal injuries.
[7] BLS data for 2020 "psychiatric hospitals and substance abuse hospitals" is a rate of 161.6 injuries per 10,000 full-time workers per year (114.2 intentional injury by another person and 47.4 unintentional injury while restraining or subduing).
[8] BLS data for 2020 "residential mental health care facilities" is a rate of 50.7 injuries per 10,000 full-time workers per year (41.3 intentional injury by another person and 9.4 unintentional injury while restraining or subduing)

Figure-1

Number and Rate of WPV Injuries for Industry Sectors in the Contemplated Scope, 2019.

Sector	NAICS	Industry	Injuries	Rate per 10,000 FTE
General hospitals, incl. emergency departments	622000	Hospitals	7,160	17.8
Behavioral Health	622200	Psychiatric and substance abuse hospitals	1600	152
	623200	Residential behavioral health facilities	3120	58.2
	621112	Offices of Physicians, Mental Health Specialists	130	26.6
Residential care facilities	623100	Nursing care facilities	780	19.1
	623300	Continuing care retirement communities and assisted living facilities for the elderly	3280	14.4
Home healthcare	621600	Home healthcare	620	6.1
Emergency medical services	621910	Ambulance Services	260	18.6
Social assistance services	624100	Individual and Family Services	300	20.5
	624200	Community Food and Housing, and Emergency and Other Relief Services	140	8.9
	624300	Vocational Rehabilitation Services	530	21.8

Source: BLS, Tables R4, R8 (2019)

Survey Results Show the Prevalence of Workplace Violence

The literature on workplace violence includes a number of surveys of healthcare and social assistance workers, which are useful for understanding the prevalence of workplace violence. Particularly because of the limitations associated with underreporting discussed below, surveys of healthcare and social assistance workers are especially useful in accurately characterizing the extent of the workplace violence risk. In the social assistance sector, for example, one survey of 175 licensed social workers and 98 agency directors found that 25 percent of social workers had experienced assault by a client, nearly 50 percent had witnessed violence in a workplace, and more than 75 percent were fearful of violence occurring. (Rey, L. 1996). A longitudinal study of 1,501 child protective services workers found that they experienced high levels of what the authors termed "nonphysical violence" (yelling, shouting, property damage) (75 percent), threats (37 percent), and physical violence (2.3 percent) the first 6 months on the job (Radey, 2021).

Similarly, in the healthcare industry, another survey of 762 nurses in a variety of inpatient settings revealed that in the prior year approximately 54 percent experienced verbal violence from patients, approximately 30 percent experienced physical violence from patients, and 76 percent of the nurses experienced at least one instance of violence involving a patient or a patient's visitor (Speroni, K.G., et. al. 2014).

A study of approximately 2,900 nursing assistants working in long-term care facilities found that 34 percent had sustained a physical injury from an assault by a resident in the prior year (Tak, S.W., et. al 2010). Reports from home healthcare workers also indicate high rates of workplace violence. In one study, 30.2 percent of home healthcare workers surveyed had experienced workplace violence at some point during their careers, and 22.3 percent had experienced it during the prior 12 months (Byon, 2020).

Another study analyzed a series of individual surveys from 1995 to 2018 that included clinicians (providing direct patient care) and non-clinicians of psychiatric inpatient units. Each individual survey encompassed the workers' prior year of experience in small clinics, mental health services, and large psychiatric hospitals that serve elderly, adults, and children. Depending on the surveyed population, a range of 25 to 85 percent of workers surveyed from the various sites reported episodes of physical aggression during the prior year (Odes, et al. 2021).

According to National Nurses United, which conducted a survey of nurses' experiences with workplace violence from 2017-2019, physical injuries resulting from WPV in the Health Care and Social Assistance sector range from minor bruising and abrasions to more serious injuries including broken bones, internal tissue damage, and even death. (NNU, 2021) Among the 402 nurses who took the survey, only 16.7 percent reported had not experienced workplace violence. In the report titled *Injury to None*, NNU cited continued and escalating experiences with type II violence (e.g., violent acts committed by patients or their visitors) in various areas of the healthcare system such as emergency rooms, outpatient clinics, pediatrics, and labor and delivery rooms (NNU, 2021).

OSHA Stakeholder Meeting on Workplace Violence

OSHA has also heard first-hand accounts of the extent and severity of the workplace violence hazard in the healthcare and social assistance industry. At a Workplace Violence Stakeholder Meeting convened at the Department of Labor in January 2017, OSHA heard testimony from workers detailing violent assaults that they or their colleagues had endured from agitated patients.

One home healthcare worker described a colleague who had been killed by her client's son, who was upset that the worker was in the home. (Ex. 0097, pg. 253)[9] Another worker, a nurse for

[9] In this document, OSHA references documents in Docket No. OSHA-2016-0014, the docket for Prevention of Workplace Violence in Healthcare and Social Assistance. This docket includes documents associated with and comments received in response to the December 7, 2016 Request for Information. OSHA has placed all references in this document in the public docket at and is available to help SERs obtain any references they would like to see. All non-copyrighted references will be available online at regulations.gov in the docket for this potential rulemaking.

over 45 years, both in psychiatric and emergency settings, described how she has been "bitten, kicked, punched, pushed, pinched, shoved, scratched and spat upon." She said that she had her life, the life of her unborn child and other family members threatened, which required security to escort her to her car. This worker also described an instance when her emergency nursing colleague was a victim of a surprise, unprovoked patient attack where she was "strangled and swung around like a little rag doll, all the while being threatened with death" by the patient. She went on to describe attacks on other emergency nursing colleagues of hers, such as "one [who] had been kicked in the head over ten times, was severely concussed, and had lasting injuries and is no longer working in nursing. Another had been attacked by a patient on PCP. [The colleague] intervened with an attack on another patient and was hit with a IV pole." (Ex. 0097, pp. 104–105)

Many of these workplace violence incidents result in severe and permanent injuries. A registered nurse at a 22-bed psychiatric unit in a major acute care hospital in Connecticut described how in the past seven years, she had suffered two very serious injuries that each required surgery.

> On October 11th, 2009, I went to work as usual at 7:00 a.m., not knowing that that day my life would suddenly change. That afternoon, as I was nearing the end of my shift, I approached a 25-year old male patient to hand him his medication and a glass of water.
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> In the next moment, I went from being a professional nurse doing my job to a helpless victim of workplace violence. Without warning, the patient suddenly became viciously violent. He punched me in my jaw with his full strength, hurdling me backward onto the floor. The impact of my body crashing down shattered my left leg at the hip. I lay on my back in excruciating pain. All of the bones and soft [t]issues in my hip were broken and torn. Only my skin held my now lifeless leg onto my body.
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> Initially, I could not comprehend what had happened. The pain was the worse I had ever experienced. I immediately felt helpless and uncertain about whether I would recover from such a catastrophic injury. My recovery was painful and difficult. It began with a complete reconstruction of my femur and hip. An orthopedic surgeon successfully put my leg back together, rebuilding my hip with supporting rods so that I would eventually walk again.
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> After surgery, I remained in the hospital for five days, followed by another three weeks

To find a reference from this document, go to http://www.regulations.gov, the Federal eRulemaking Portal. From there, references are found by looking up the document ID number. The docket number for this rulemaking, and therefore the beginning of each document ID number, is OSHA-2016-0014. References to documents in the docket are given as "Ex." followed by the document number and, in the case of the longer documents, such as the transcript of the public meeting, the page number. For example, Ex. 1, the Request for Information, is Document ID Number OSHA-2016-0014-0001. Likewise, Ex. 0097, the transcript from the January 7, 2017 Workplace Violence Stakeholder Meeting, is Document ID Number OSHA-2016-0014-0097.

> of intensive rehabilitation in an inpatient rehabilitation facility. After an additional six months of outpatient physical therapy, I was cleared to return to work. I did so and continued to work on the same psych unit to this day.
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> My other injury occurred just last May 7th. The injury happened as I was seated at a desk in the hallway, entering patient progress notes into a computer. A 50-year old female patient with a known history of violence, who was supposed to be restricted to her room, walked down the hall towards me. As she reached my vicinity, she grabbed my left upper arm with her fist and with her left hand she proceeded to make a punch to my face. A security guard assigned to the unit was nearby and pulled her away before she slugged me. However, the twisting motion of my body resulted in two torn meniscii in my right knee. Subsequently, medical evaluation determined that I would not recover without surgical intervention.
>
> After the surgery and physical therapy, I recovered and was cleared to return to work. Again, I was out of work for six months. Both of these injuries were seriously traumatic, physically, emotionally and psychologically. Both workplace violence events necessitated trauma counseling. The second event required extensive counseling for PTSD.
>
> However, at times even after counseling I still feel traumatized and vulnerable, feelings that never completely go away. (Ex. 0097, pp. 66-72)

OSHA heard testimony from several dozen nurses within various professional settings, emergency medical technicians, home healthcare workers, psychiatric technicians, physicians, and their representatives describing similar violence that they had either experienced or witnessed on the job. (Ex. 0097)

Media Reports on Workplace Violence

Severe WPV incidents have also received attention in the media. One incident involved a psychiatric technician who was strangled with his own lanyard by a patient in August 2012 (Romney, 2012). In another incident in May 2017, an incarcerated individual was receiving care at an Illinois hospital and was left unshackled by the guard because of his requests to use the bathroom. The inmate took the gun of the guard and escaped, and the guard ran and hid without alerting the hospital that the inmate had escaped and was armed. The inmate took one nurse hostage and severely physically abused her, and when another nurse entered the room, he took her hostage and left for another secluded area, where he beat and raped her at gunpoint (NBC, 2017).

In November 2020, a Seattle social assistance case manager was stabbed 12 times and killed by a disgruntled client who thought he was going to be evicted. Surveillance video showed him

entering her office with a large knife. The case manager's screams alerted a co-worker, who recognized the client and witnessed him stabbing the case manager. The client then chased the co-worker, and after the co-worker locked herself in her office, the client continued to attack the case manager, leaving the knife in her back. The client attacked another worker as he left the building and was later arrested (Green, 2020).

In October 2021, a pregnant nurse in a Florida hospital behavioral unit was administering medication to one patient when another patient entered the room, attacked her and attempted to kick her, shoving her against a wall. The attack killed her unborn child (Mark, 2021).

More recently, in January 2022, an Illinois Department of Child and Family Services (DCFS) investigator was performing a home visit alone in response to the welfare of six children. The investigator was stabbed to death, and the police took a person who lived at the house into custody. (Spearie, 2022)

Underreporting

While all of this data and these personal accounts indicate that workplace violence is significantly worse for workers in healthcare and social assistance than for workers in other industries, that data may still obscure the significance of the risks due to underreporting. Since BLS and other agencies rely on employers to report injury and illness data, the injury rates associated with workplace violence likely underestimate the risk faced by healthcare and social assistance workers. OSHA has long recognized that underreporting of all types of injuries (regardless of cause) exists in healthcare and social services, and underreporting obscures and understates the true extent of problems that may exist. In 2013, OSHA completed an analysis of its National Emphasis Program on Injury and Illness Recordkeeping. Through reconstruction of employee records by inspectors, OSHA found that within nursing care facilities in calendar years 2007 and 2008, over 20 percent of employee injury cases that involved days away from work were either not recorded or incorrectly recorded by the employer (OSHA, 2013).

The U.S. Government Accountability Office (GAO) has also identified problems with underreporting of workplace violence incidents in the healthcare industry. In its 2016 report "Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence," it analyzed four national datasets (the Survey of Occupational Injuries and Illnesses (SOII) and Census of Fatal Occupational Injuries (CFOI) from BLS, the National Electronic Injury Surveillance System (NEISS-Work) from Centers for Disease Control (CDC)/National Institute for Occupational Safety and Health (NIOSH), and the National Crime Victimization Survey (NCVS) from the Bureau of Justice Statistics) to evaluate the rate of workplace violence committed against healthcare workers.

The GAO analysis found that workers in healthcare facilities experience "substantially higher estimated rates of nonfatal injury due to workplace violence compared to workers overall." GAO concluded that the full extent of the problem with workplace violence in healthcare and social assistance could not be known for three main reasons:

> 1) Differences in the criteria each data set used to record workplace violence cases. The SOII and NEISS-Work datasets do not include workplace violence that does not result in severe injuries that require days off from work or an emergency room visit. The NCVS data does not include cases that are not considered crimes.
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> 2) Employees underreporting workplace violence incidents. GAO also conducted a systematic review of published studies from January 2004 to June 2015 and several studies indicated that workplace violence incidents are often underreported. The studies GAO reviewed estimated that healthcare workers formally report between just seven to 42 percent of workplace violence incidents, indicating that a substantial proportion of workplace violence incidents are not reported.
>
> 3) Employer inaccuracies in reporting workplace violence incidents. GAO cited OSHA and BLS research from 2012 stemming from a review of the OSHA National Emphasis Program on Recordkeeping and Other Department of Labor Activities Related to Accuracy of Employer Reporting of Injury and Illness Data (for years 2007 and 2008) that indicated that employers do not always record, or accurately record, workplace injuries in general. For example, an employer may record a case but not correctly categorize it as a case that involved days away from work, restricted work activity, or job transfer. Specifically, in this instance, OSHA found that within nursing care facilities over 20 percent of employee injury cases that involved days away from work were either not recorded or incorrectly recorded by the employer (GAO, 2016 & OSHA, 2012).

The literature on workplace violence has often identified underreporting as an issue, as well. For example, Arnetz, et. al. (2015) looked at underreporting of workplace violence events in an American hospital system by surveying 2,010 healthcare workers, 22 percent of whom responded. The study found that 88 percent of those workers participating in the survey responded they had experienced an incident within the past year, but only 12 percent indicated that they had formally reported the incident to their employers through the hospital's mandatory electronic reporting system. Employees who were injured or had lost time from work were more likely to formally report a workplace violence incident.

Likewise, Snyder, et. al., (2007), found a large proportion of workplace violence incidents go unreported. The study investigated aggressive incidents from patients against certified nursing assistants (CNAs) in a sample of 76 CNAs across six geriatric care facilities. The results indicate that these CNAs experienced a median of 26 aggressive incidents over the course of the two-

week study, but that approximately 95 percent of these incidents were not reported to the facility. Reasons for not reporting included: 1) "The resident did not mean to do it;" 2) "I was not seriously injured;" 3) "I expect such incidents to occur as part of my job;" 4) "It is too difficult or time consuming to report;" 5) "The administration will not take action based on my report;" 6) "Reporting is not required by facility rules or requirements -- unless behavior is abnormal for a patient" (Ex. 0057).

Another study described 827 violent events among 213 emergency department health care workers at six hospitals over a nine-month period. Eligible study participants provided direct patient care and worked 20 hours per week or more. Study participants included physicians, nurses, patient care assistants, paramedics, social workers, physician assistants and nurse practitioners. The study reports an estimated average of 5.528 violent events per year per person (4.017 physical threats, 1.51 physical assaults per person over one year). Workers filed a safety report 42 percent of the time and filed a police report 5 percent of the time. This suggests underreporting of safety reports of 58 percent (Kowalenko, 2013).

In a survey of 5,385 workers from two large hospital systems, one in Texas and the other in North Carolina, 39 percent indicated that they experienced at least one violent event (physical assault, physical threat, or verbal abuse, by a patient or visitor) in the prior year. Among these workers, 75 percent indicated they reported the event in some way (e.g., co-worker, manager, first report of injury (FRI) system), but only 9 percent indicated they reported into a formal occupational injury/safety reporting system. Workers were unclear about when and how to report and decided whether to report based on the event circumstances. Workers were more likely to report if they were physically assaulted, or physically threatened, if they incurred an injury, or when they were worried about personal safety at work. Also, 35.3 percent of the workers did not report because they felt that the patient or visitor had no intent to harm, subjectively differentiating the intent based on the patient's medical condition (Pompeii, et. al. 2016).

In a meta-analysis of 21 studies between January 1, 2005 and March 20, 2019, researchers found the prevalence of physical type II violence for professional home health workers (HHWs) in one year was higher than for paraprofessionals, although this could be because paraprofessionals underreport more often. Paraprofessionals normally have less job security, may not have as much familiarity working in a private home or establishing safe boundaries and may experience a fear of retaliation if they report. (Byon, et. al., 2020)

In a survey study within a sample of 242 emergency staff workers, 37 percent reported experiencing physical assault within the past six months. Men in the study had a higher perceived sense of safety than women. Although the security staff in the sample were more likely to report WPV formally, possibly because they were familiar with the process, 69 percent of the staff never formally reported physical violence due to barriers such as the belief that violence is

"part of the job," difficulty in defining reportable workplace violence, navigating the complexities of the reporting process, no time at work to report incidents, fear of retribution, and perceived lack of manager, supervisor or institutional support. (Mcguire, et al. 2021).

Additionally, when OSHA issued its request for information on workplace violence in 2016, several commenters who responded included comments about underreporting of workplace violence. A commenter from Drexel University School of Public Health with expertise in Emergency Medical Services (EMS) shared an analysis of underreporting from EMS responders:

> Underreporting of the issue is a great cause for concern. One of the limitations that we noted from the literature is the perception that assaults are an inherent to the profession and reporting violent incidents implies an inability to perform their job competently (Corbett, 1998). Attitudes such as these have been suggested as a cause for significant underreporting of violence by EMS responders (Pozzi, 1998). A survey of 1,500 medical providers in New Mexico found that 56% of EMS respondents stated that violence is "just a part of the job" (Feiner, 1995). And although a large percentage believe violence is a part of the job, 40% believed that if no one was injured during the incident that there was no need to report (Feiner, 1995). Other studies show higher frequencies, up to 71%, believing that violence is a part of their job (Pozzi, 1998). In a survey of Canadian paramedics, 62% of participants stated that no actions were taken by most paramedics in response to the violent events (Bigham et al., 2014). In that same study, 61% of participants did not report the violence to a superior or authority and 81% did not formally document the occurrence in the patient care report (Bigham et al., 2014). Similarly, one study found that only 31% of all violent encounters were properly mentioned in the paramedic narrative (Mock, et al., 1998). (Ex. 0194)

National Nurses United (NNU) commented that:

> It is important for OSHA to note that many sources of data on workplace violence underreport its prevalence. This is, in part, due to the mistaken understanding in healthcare that workplace violence is part of the job. Oftentimes, hospital supervisors and managers perpetuate this dangerous view of workplace violence, reifying the idea that reporting incidents is futile. In focus group-style discussions, NNU members have reported that supervisors and managers respond to reports of workplace violence with comments or actions that communicate to workers that it is just "part of the job." Also reflected in NNU members' experience with workplace violence, it is common for supervisors and managers to discourage employees from making reports of violence from patients. RNs also describe in discussions on workplace violence that they are hesitant to report violence from patients with dementia or other conditions that cause disorientation and combativeness, because they fear their patients, for whom they serve as

> advocates, will be criminally punished, otherwise blamed, or denied care as a result. These reasons for underreporting underline the importance of clear communication procedures to effective workplace violence prevention plans and of protections, like non-retaliation policies, for reporting incidents and concerns about risks of violence. All incidents of violence must be reported for the prevention plan to be fully effective, but employees need training on why reporting is important and how to report without fear of reprisal for themselves or their patients. (Ex. 0235)

OSHA is troubled by these data and believes that a standard on prevention of workplace violence in healthcare and social assistance will both protect workers at risk as well as bring clarity to the extent of the hazard in this industry.

Enforcement of the General Duty Clause and Current Non-Mandatory Guidance is Inadequate to Substantially Reduce the Risk of Workplace Violence in the Healthcare and Social Assistance Sectors

OSHA currently enforces Section 5(a)(1) of the OSH Act, 29 U.S.C. § 654(a)(1), against employers that expose their workers to the recognized workplace violence hazard. Also known as the General Duty Clause, Section 5(a)(1) requires that "Each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees."

Yet OSHA's existing enforcement mechanisms are insufficient because section 5(a)(1) does not specifically prescribe how employers are to eliminate or reduce their employees' exposure to workplace violence, so even in cases where OSHA prevails, the employer need not necessarily implement the specific abatement measure(s) OSHA established would materially reduce the hazard – they can choose alternatives and OSHA must then prove that the hazard remains even after implementation of those alternatives. In addition, when relying on § 5(a)(1), OSHA must demonstrate *in each case* that workplace violence is a hazard and that specific controls will address that hazard, whereas an OSHA standard that requires or prohibits specific conditions or practices establishes the existence of a hazard comprehensively and establishes the effectiveness and feasibility of controls to the address the hazard. In this expansive and growing industry, reliance on § 5(a)(1) is therefore a relatively inefficient means of ensuring the safety of more than 20 million employees from the recognized hazard of workplace violence.

Based on a November 2021 OSHA review of enforcement activity conducted between 2010-2020, OSHA had conducted 779 inspections related to workplace violence, resulting in 63 General Duty Clause citations and 448 Hazard Alert Letters (HALs). The majority of those inspections (530 inspections, 51 citations, 314 HALs) occurred in healthcare or social service facilities. (OSHA, 2021)

OSHA first issued guidance on reducing workplace violence in healthcare and social assistance more than twenty years ago. OSHA published the first guidance documents on this topic in 1996 titled *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers* and launched a Nursing Home Health and Safety Initiative. NIOSH also began to focus on this issue in 1996, when it published a report titled *Violence in the Workplace* which indicated that workplace violence was high in the healthcare and social assistance sectors. (NIOSH, 1996).

Below OSHA summarizes some its additional guidance, enforcement, and reports related to workplace violence prevention in healthcare and social assistance since 1996.

In 2004, OSHA revised its *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*. This revision created an outline of a workplace violence prevention program for healthcare and social services sectors, including the five main components:

1. Management Commitment and Employee Involvement: Management should equally commit to the safety of workers and patients/clients/residents and employees should be involved and provide feedback on the design, implementation, and evaluation of the program.
2. Worksite Analysis: Employers should analyze and track records of workplace violence and analyze workplace security.
3. Hazard Prevention and Control: Employers should implement engineering controls, workplace adaptations, and administrative and work practice controls to minimize risk.
4. Safety and Health Training: Training should include the workplace violence prevention policy, Risk factors that cause or contribute to assaults, and early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults.
5. Recordkeeping and Program Evaluation: Employers should record incidents of abuse, verbal attacks or aggressive behavior that may be threatening and measure improvement based on lowering the frequency and severity of workplace violence.

In 2011, OSHA issued Directive CPL 02-01-052 Enforcement Procedures and Scheduling for Occupational Exposure to Workplace Violence. This Directive provided instruction on enforcement procedures for OSHA Compliance Safety and Health Officers (CSHOs) during workplace violence inspections. It clarified OSHA policies and procedures related to workplace violence inspections with specific criteria for CSHOs in determining whether to cite an employer for failing to protect its employees from workplace violence in violation of the General Duty Clause.

In 2015, OSHA published *Caring for Our Caregivers: Strategies and Tools for Workplace*

Violence Prevention in Healthcare. This resource provided data and tools to assist healthcare facilities with the development and implementation of safety and health programs addressing a variety of healthcare-based risks, including development of a workplace violence prevention program, specifically.

In 2016, OSHA revised its *Guidelines for Preventing Workplace Violence for Healthcare and Social Assistance Workers*. This version addressed risk factors within specific sectors of healthcare and social services, including:

- Hospital settings;
- Residential treatment settings including institutional facilities such as nursing homes, and other long-term care facilities;
- Non-residential treatment/service settings including small neighborhood clinics and mental health centers;
- Community care settings including community-based residential facilities and group homes; and
- Field-based work settings including home healthcare workers or social workers who make home visits.

In 2017, OSHA issued Directive CPL 02-01-058, Enforcement Procedures and Scheduling for Occupational Exposure to Workplace Violence, a guidance document for its CSHOs when conducting workplace violence investigations. This revision to the previous Directive CPL 02-01-052 from 2011 clarified the different types of healthcare settings where workplace violence incidents are reasonably foreseeable. It also identified steps employers can take to reduce the workplace violence hazard.

Despite the quantity of guidance and the enforcement activities OSHA has pursued, both OSHA's Fatality and Catastrophe Investigation Summaries and BLS's Census of Fatal Occupational Injuries (CFOI) show an increase in the number of workplace violence-related fatalities among health care and social assistance workers between 2018 and 2020. These two sources of data differ in that Fatality and Catastrophe Investigation Summaries are developed solely after OSHA conducts an inspection in response to a specific fatality or catastrophe. By contrast, BLS CFOI data are a more representative sample of data since they are comprised of reports for all fatal work injuries as long as the decedent was engaged in an activity related to work, regardless of whether the decedent was working in a job covered by OSHA or another federal or state agency.

OSHA Information System (OIS) data from fatality inspections showed an increase from five workplace violence-related deaths in 2018 to ten deaths in 2020 (100 percent increase). CFOI data showed an increase from 36 deaths in 2018 to 52 deaths in 2019 (44 percent) (BLS, CFOI, 2019)

OSHA has long considered the appropriateness of regulatory action to address workplace violence.[10] OSHA has received recommendations to issue a rule on workplace violence in the healthcare and social assistance sector. For instance, in GAO's 2016 report "Workplace Safety and Health: Additional Efforts Needed to Help Protect Healthcare Workers from Workplace Violence," GAO recommended that OSHA consider whether additional action, such as developing a standard, is needed.

In 2016, OSHA published a Request for Information (RFI) Preventing Workplace Violence in Healthcare and Social Assistance. *Prevention of Workplace Violence in Healthcare and Social Assistance*, 81 Fed. Reg. 88147 (Dec. 7, 2016). OSHA received over 150 comments from the public in response to the RFI document. Comments were submitted from a range of organizations and individual respondents with interest and expertise in healthcare and social assistance. Overall, OSHA received strong support for proceeding with the rulemaking process for a potential standard on preventing workplace violence in Healthcare and Social Assistance, including from commenters such as The American Association of Occupational Health Nurses, Inc. (AAOHN) (Ex. 0168), the American Federation of State County and Municipal Employees (AFSCME) (Ex. 0234), The United Steelworkers (Ex. 0210), the Service Employees International Union (SEIU) (Ex. 0236), and multiple state level associations (Ex. 0239, 0233, 0234, 0215, 0095, 0241, and 0111). The need to protect healthcare workers from violence was the most frequently recurring reason stated for supporting the potential rule in the comments submitted in response to the RFI.

Multiple public interest, professional, worker advocacy, and governmental organizations have also recommended OSHA consider regulatory action to address the workplace violence hazard. In 2013, Public Citizen published "Health Care Workers Unprotected: Insufficient Inspections and Standards Leave Safety Risks Unaddressed," which recommended OSHA promulgate a workplace violence standard. The Joint Commission, which recently added workplace violence prevention elements to their standards for several areas of evaluation criteria chapters, said "The Joint Commission…welcomes the approach of a[n OSHA] workplace violence standard, guidance, and tool kits." (Ex. 0221)

[10] In the absence of federal regulatory action, multiple states have issued regulations to address the workplace violence hazard in the healthcare industry. Ten states have enacted laws that require healthcare employers to establish a workplace violence prevention plan or program: California (Title 8 Section 3342, 2016), Nevada (Assembly bill 348, 80 Cong, 2019), Connecticut (Public Act No. 11-175, Substitute Bill 970, 2011), Illinois (405 ILCS 90, 2013, 210 ILCS 160/ 2019), Maine (22 MRS § 1832, 2011) Maryland (SB 483, 2014), New Jersey (P.L Chapter 236, 2008), New York (12 NYCRR Part 800.6, 2007), Oregon (Chapter 654, 2017) and Washington (Title 49, Chapter 49.19RCW, 1999). California became the first state to adopt an occupational health and safety standard requiring healthcare facilities to take certain specific steps to establish, implement, and maintain an effective workplace violence prevention plan. Louisiana, Nevada, and Illinois recently enacted similar regulations to require certain healthcare employers to create and implement unit-specific workplace violence prevention programs and to report incidents.

OSHA received two workplace violence rulemaking petitions in 2016, one from a coalition of labor organizations (American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), American Federation of Government Employees (AFGE), AFSCME, SEIU, Teamsters and United Steelworkers, and American Federation of Teachers (AFT)), and the other from the National Nurses United (NNU). OSHA granted the rulemaking petitions on January 10, 2017, stating that "workplace violence is a serious occupational hazard that presents a significant risk for healthcare and social assistance workers" and that a workplace violence standard "is necessary."

Based on the evidence that OSHA has collected through years of enforcement activities, analysis of BLS data and occupational injury literature, as well as continued stakeholder input, OSHA has concluded that the issue of workplace violence in healthcare and social assistance settings is a serious problem that puts millions of U.S. workers at increased risk of injury.

OSHA preliminarily believes that development and enforcement of a workplace violence standard would reduce the risk of workplace violence in the healthcare and social services industry. A workplace violence standard would help to clarify employer obligations and the measures necessary to protect employees from such violence. OSHA's enforcement experience indicates that addressing hazards through rulemaking, rather than through enforcement of the general duty clause, more efficiently and effectively reduces risk. OSHA has concluded that there is a need to initiate the rulemaking process for a standard intended to reduce the risk of physical harm to employees working in healthcare and social assistance sectors.

The Measures in This Draft Standard Would Considerably Reduce the Risk of Workplace Violence in the Healthcare and Social Assistance Industry

General Structure of the Proposed Regulation

OSHA's draft regulatory framework addresses, and aims to reduce, the prevalence and the severity of workplace violence in health care and social assistance settings. For the purpose of this potential standard, OSHA focuses solely on type II workplace violence, which are violent acts committed by patients, clients, and their visitors upon workers within a healthcare or social assistance setting. OSHA is defining "workplace violence incident" as any violent act (including physical assault and threat of physical assault) directed toward persons at work or on duty by patients, clients, or their visitors. These incidents may or may not result in injury. Examples of physical assaults include slapping, beating, rape, homicide, and the use of weapons such as firearms and knives. Threats of physical assaults include expressions of intent to cause physical harm, either verbal, written, or through body language.

The agency is therefore considering to propose an occupational safety rule on employee exposure to workplace violence. Some recognized risk factors for workplace violence in healthcare and social assistance, from the OSHA *Guidelines for Prevention of Workplace Violence in Healthcare and Social Assistance,* include:

- Direct patient care;
- Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff;
- Poor environmental design of the workplace that may block employees' vision or interfere with their escape from a violent incident;
- Lack of means of emergency communication;
- Inadequate security;
- Unrestricted movement of the public in clinics and hospitals; and
- Working alone in a facility or in patients' homes.

To address such risk factors, OSHA's draft standard uses a programmatic, performance-based approach with a series of provisions that would require employers to develop and implement workplace violence prevention policies and involve employees in the creation and implementation of a workplace violence prevention program. Employers would be required to perform regular hazard assessments based on their own injury records as well as identify and mitigate hazards in the work environment and hazards associated with work practices. OSHA is considering training requirements for employees and their supervisors, a specific workplace violence recordkeeping log, incident investigation procedures, and an anti-retaliation policy to encourage employee reporting of workplace violence incidents.

The five core components of a workplace violence prevention program identified in OSHA's "Guidelines for Preventing Workplace Violence for Healthcare and Social Services Workers" — (1) Management Commitment and Employee Participation; (2) Worksite Analysis and Hazard Identification; (3) Hazard Prevention and Control; (4) Safety and Health Training; (5) Recordkeeping and Program Evaluation — are also the five core components upon which OSHA has established the framework for this draft regulation. Research indicates that such measures can meaningfully reduce workplace violence in healthcare. When hospitals or social service organizations have adopted similar programmatic performance-based approaches, they have recorded a reduction of workplace violence incidents.

The literature supports this approach. For instance, Noga, et al., 2020, described how, in its efforts to have more regulatory oversight of workplace violence in healthcare, the Massachusetts Health & Hospital Association developed a 5-step continuous process improvement plan based largely on OSHA's workplace violence guidelines. The plan included identifying issues, receiving stakeholder input, collecting and sharing data and information statewide, and creating

guidelines for hospitals. The authors found this represented a serious statewide investment in preventing workplace violence, collecting and reviewing data, and improving established interventions in hospital settings (Noga, et al., 2020). Additionally, Nevels, et al., discussed H.R. 1309, a bill in Congress that mirrors much of OSHA's draft standard, and argued that the approach outlined in the bill was a significant improvement over enforcement through the General Duty Clause. (Nevels, et al., 2020).

Programmatic Approach with Management Commitment and Employee Involvement

The programmatic approach that OSHA is considering in this draft standard for prevention of workplace violence in healthcare and social assistance settings is consistent with the principles of the International Labour Organization's Convention No. 190 – Eliminating Violence and Harassment in the World of Work (ILO, 2019). OSHA believes that this programmatic approach for promotion of management commitment and employee involvement will promote a safety culture in covered establishments. The leadership of management in providing full support for the development of the workplace's program, combined with worker involvement, is critical for the success of the program.

The American Nurses Association (ANA) supported this approach, noting that it is critical for both RNs and their employers to be involved in developing, implementing, and improving workplace violence prevention programs (Ex. 0162). The International Association for Healthcare Security & Safety (IAHSS) also supported this concept and referred to its Guideline 01.09 *Violence in Healthcare* that recommends "a multidisciplinary team that includes representatives from security, clinical, risk management, human resources, ancillary/support staff, executive leadership, and external responders, as appropriate, to develop and maintain the workplace violence program and prevention strategies." It stated that participation and collaboration within the framework of a multidisciplinary approach helps "to guide the organization's development of safety, security, and workplace violence prevention and response plans" (Ex. 0151).

Through involvement and feedback, workers can provide useful information to employers to design, implement and evaluate the program. In addition, workers with different functions and at various organizational levels bring a broad range of experience and skills to program design, implementation, and assessment.

Worksite Analysis and Hazard Identification, Prevention, and Control

A worksite analysis involves a step-by-step assessment of the workplace to find existing or potential hazards that may lead to incidents of workplace violence. The assessment should include a records review, a review of the procedures and operations for different jobs, employee surveys and workplace security analysis. Once the worksite analysis is complete, it should be

used to identify the types of hazard prevention and control measures needed to reduce or eliminate the possibility of a workplace violence incident occurring. In addition, it should assist in the identification or development of appropriate training. Employee questionnaires or surveys are effective ways for employers to identify potential hazards that may lead to violent incidents, identify the types of problems workers face in their daily activities, and assess the effects of changes in work processes.

The literature supports this kind of worksite analysis. For example, Arnetz et. al. (2017) conducted a study within a multi-site hospital system in the Midwest United States that had approximately 15,000 employees and an electronic database for reporting workplace violence. The study involved the authors first analyzing data from prior workplace violence incidents to determine what hospital units had high rates of violence and then conducting walkthroughs with supervisors and staff members to identify interventions, which resulted in the supervisors developing an action plan. The action plans included interventions such as security assessments of units and recommendations for shortcomings from hospital safety staff; monthly meetings with hospital safety staff, occupational health and safety staff, and security staff; increased frequency of security rounds; de-escalation trainings; installation of panic alarms; increased lighting in surrounding parking lots; active shooter trainings; and more balanced scheduling of staff in general. The authors concluded that this approach was effective in decreasing the risk of patient-on-worker violence and injury.

Okundolor, et. al. (2021) described a large urban academic hospital that evaluated baseline data and issues in the hospital and developed an action plan based on that analysis. The action plan involved a variety of interventions: "(1) increasing behavioral response team drills, (2) implementing [preshift briefings for staff on each patients' behaviors and propensity for violence], (3) screening for patients' risk for violence, (4) posting signage to communicate patients' violence propensity, (5) implementing mitigating countermeasure interventions, (6) conducting post-assault debriefing, and (7) providing post-assault support." Staff perceived self-efficacy increased from 78 percent to 95 percent after attending at least two behavioral response team drills. Physical assaults on staff by patients decreased to zero in this psychiatric ER, which was sustained for one year. (Okundolor, et al., 2021).

Drummond et. al described the success experienced by one general hospital in reducing violent behavior when it first tracked data regarding repeated violence of patients and then used that data to identify and manage high-risk patients through the use of computerized warnings or "flags" on patient charts. The number of incidents declined by 91.6 percent and visits by employees to the medical center for any reason decreased by 42.2 percent. (Drummond, et. al. 1989).

Worksite analysis and hazard identification require employers to examine the relationship between employees, tasks, tools, and the work environment. Theis involves reviewing the

procedures and operations connected to specific tasks or positions to identify hazards related to workplace violence and then modifying those procedures and operations to reduce the likelihood of violence occurring. OSHA believes that employers that comply with the hazard assessment and control measure provisions in this draft standard can achieve significant reductions in the rates and severity of workplace violence incidents.

Safety and Health Training

Education and training are key elements of a workplace violence prevention program, and help ensure that all staff members are aware of potential hazards and how to protect themselves and their coworkers through established policies and procedures. Training topics included in OSHA's draft standard include de-escalation and management of assaultive behavior, as well as personal safety training on how to prevent and avoid assaults and training that covers the policies and procedures associated with all aspects of an employer's workplace violence prevention program (WVPP).

National Nurses United highlighted the importance of in-person and hands-on training that discusses the WPV hazards that employees may encounter in the course of their jobs. In addition, they stated that training should address prevention measures, and the policies, procedures, and communication methods established by the employer regarding WPV. National Nurses United also advocated for all employees to receive an initial training when the employer's WPV prevention plan is first established, upon hire, or upon assignment to new duties for which training was not previously provided. WPV prevention training should have an interactive format where questions are answered by a person knowledgeable about the topic.

Studies have indicated the effectiveness of training. For example, a sample of 255 home healthcare workers completed a case-controlled study associated with computer-based training (CBT) on WPV prevention. 129 participants took the CBT supplemented with peer support and facilitation and the other 126 took the CBT only. The authors found that training participants, controlling for group, exhibited an increase in workplace violence knowledge and awareness, (they "significantly improved from a mean of 70.6 percent correct responses in the pre-test to a mean of 91.4 percent correct responses on the immediate post-test"). All participants experienced a statistically significant increase in their confidence to respond to workplace aggression. All participants also reported a decline in workplace violence, including sexual harassment and verbal aggression. (Glass, et al. 2017).

Education and training ensure that employees, supervisors, and managers are able to recognize and control hazards, allowing them to work more safely and contribute to the development and implementation of the workplace violence prevention program. OSHA believes that training provides employers, managers, supervisors, and employees with the knowledge and skills needed

to do their work safely and to avoid creating hazards that could place themselves or others at risk, as well as awareness and understanding of workplace violence hazards and how to identify, report, and control them.

Incident Investigation, Recordkeeping, Program Evaluation, and Preventing Retaliation

Incident investigation, recordkeeping and evaluation of the violence prevention program are necessary to determine its overall effectiveness and identify any deficiencies or changes that should be made. Post-incident investigation and evaluation are important components to an effective violence prevention program. The thorough investigation of incidents of workplace violence will provide a roadmap to avoiding fatalities and injuries associated with future incidents. The purpose of the investigation should be to identify the "root cause" of the incident. Records can be especially useful to large organizations for this purpose and may include:

- The OSHA Log of Work-Related Injuries and Illnesses (OSHA Form 300),
- Medical reports of work injury, workers' compensation reports and supervisors' reports for each recorded incident,
- Records of reports conducted by security personnel in response to verbal attacks or aggressive behavior that may be threatening,
- Documentation of minutes of safety meetings,
- Records of hazard analyses and corrective actions recommended and taken, and
- Records of all training programs, attendees, and qualifications of trainers.

OSHA has also included an anti-retaliation provision in the draft standard so that employees who may perceive that they may be punished for reporting incidents will feel more secure in doing so.

OSHA's draft standard includes a specific Workplace Violence Incident Log that the agency expects would be particularly useful for this purpose. The studies conducted by Arnetz et. al. (2017), Okundolor, et al., (2021), and Drummond, et. al. (1989), summarized above, demonstrate the importance of accurate recordkeeping and evaluation with respect to hazard assessment, implementation of control measures, and program evaluation to reduce the risk of workplace violence.

The International Association for Healthcare Security & Safety (IAHSS) supports this kind of program, and has recommended that all workplace violence threats be reported, documented, reviewed, and assessed to determine opportunities for improvement (Ex. 0151). OSHA believes it is important that responsible parties (including managers, supervisors and employees) reevaluate policies and procedures on a regular basis to identify deficiencies and take corrective action.

Based on these studies and the evidence presented by stakeholders, OSHA believes that the measures in the draft standard would considerably reduce the risk of workplace violence faced by workers in the healthcare and social assistance industries. In the following pages, Sec IV-Draft Regulatory Text presents additional details with regard to the provisions included in OSHA's draft regulatory text. OSHA welcomes SER feedback with respect to the specific provisions in the draft.

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Section IV-a. Prevention of Workplace Violence in Healthcare and Social Assistance Draft Regulatory Text

29 CFR 1910.1031

(a) Scope and Application. this standard applies to all employers with employees that work in:

(i) Hospitals, including emergency departments;
(ii) Psychiatric hospitals and residential behavioral health facilities;
(iii) Ambulatory mental healthcare and ambulatory substance abuse treatment centers;
(iv) Freestanding emergency centers;
(v) Residential care facilities;
(vi) Home healthcare;
(vii) Emergency medical services; and
(viii) Social assistance (excluding child day care centers).

(b) Definitions. For the purposes of this standard, wherever the terms below are used, they are defined as follows:

Alarm means a mechanical or electronic device by which employees can summon assistance to respond to an actual or potential workplace violence emergency. Such devices include wall or desk-mounted panic alarm buttons, personal panic alarm buttons, emergency alarms, or other two-way mobile monitoring personal emergency communications devices that do not rely upon employee vocalization/shouting for assistance.

Ambulatory mental healthcare facilities mean facilities such as offices of psychiatrists, psychologists, mental health specialists, mental health practitioners, or substance abuse centers that provide mental health services primarily on an outpatient basis.

Designated program administrator means an individual designated by the employer to provide logistical oversight and to be responsible for the coordination and management of the administrative and technical oversight for all elements of the workplace violence prevention program (WVPP). The designated program administrator must have the knowledge, skills, or training to implement and oversee the program effectively. If the designated program administrator does not have the knowledge, skills, or training necessary to implement and oversee the program effectively, then they must consult with appropriate personnel who have such knowledge, skills or training to ensure that the WVPP is implemented and overseen effectively.

Direct patient / client / resident care means job duties that involve the delivery of healthcare services or social assistance services with hands-on or face-to-face contact with patients/clients/residents. Employees who provide direct patient/client/resident care include nurses, physicians, nursing assistants, patient care assistants, technicians, and other healthcare workers, social workers visiting client homes, as well as employees providing emergency medical services.

Direct patient / client contact means job duties where employees perform support work that requires them to be in patient care areas. Such work includes environmental services, engineering services, laundry services, meal delivery, information technology, and others. For purposes of SBREFA, OSHA also considers security staff to belong in this category.

Emergency medical services mean paramedics, emergency medical technicians (EMTs), and firefighters cross-trained and performing services as paramedics or EMTs.

Engineering Controls mean a physical aspect of the built space or a device that removes or reduces a hazard, or creates a barrier between an employee and the hazard. Some examples of engineering controls include access controls to employee-occupied areas, metal detectors (installed or handheld), enclosed workstations with shatter-resistant glass, deep service counters or other means to physically separate patients/clients/residents and their visitors from employees, separate or isolation rooms or treatment areas for patients with a history of violence, locks on doors, removing access to or securing items that could be used as weapons, affixing furniture to the floor, closed-circuit television monitoring and video recording, other means of assuring visibility such as mirrors and improved illumination, and personal alarm devices.

Environmental risk factor means a risk factor that is attributable to the layout, design, and amenities of the physical workspace or the community wherein services are provided, including work in neighborhoods with high crime rates.

Establishment means a single physical location where business is conducted or where services or industrial operations are performed. For activities where employees do not work at a single physical location, such as emergency medical services or home healthcare, the establishment is represented by main or branch offices that either supervise such activities or are the base from which personnel carry out these activities.

High-risk service areas mean settings where there is an elevated risk of workplace violence incidents. These services and settings include emergency rooms/emergency admissions/triage areas, psychiatric care, behavioral healthcare, substance abuse treatment, home healthcare, social assistance, emergency medical services, and other services deemed to be of high-risk for violence by the employer. An area where a workplace violence incident has occurred in the previous three years is considered to be high-risk unless the employer has a written determination demonstrating that this designation is not appropriate.

Home healthcare and field-based social assistance means care or services provided at the patient/client/resident's residence or other site of care where the patient/client/resident may temporarily reside such as a rehabilitation center or group home.

Host employer means an employer that owns, operates, or controls the operation of a fixed-establishment work setting (e.g., hospital, behavioral health center).

Individual Responder means an employee designated to respond to workplace violence incidents who has received an advanced level of instruction for response.

Organizational risk factor means a factor resulting from the policies, procedures, work practices, or culture of the organization. Examples include working when understaffed, high employee turnover, unrestricted movement of the public in clinics and hospitals, the perception that violence is tolerated within the organization, the patient/client/resident mix, and nature of services provided.

Psychiatric hospital means a hospital primarily engaged in providing diagnostic, medical treatment, and monitoring services for in-patients with acute mental illness or substance abuse disorders. The treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements.

Residential behavioral health facilities mean facilities primarily engaged in providing residential care and treatment for patients with chronic mental health and substance abuse illnesses.

These facilities provide room, board, supervision, and counseling services. Although medical services may be available at these establishments, they are incidental to the counseling, mental rehabilitation, and support services offered. These establishments generally provide a wide range of social services in addition to counseling.

Residential care facilities mean facilities that provide residential care combined with either nursing, supervisory, or other types of assistance as required by the residents. These establishments include those engaged with providing nursing home services for elderly and rehabilitative clients, and assisted living for the elderly. These establishments provide room, board, supervision, and counseling services. Although medical services may be available at these establishments, they are incidental to the primary support services offered.

Triage means the area(s) of admission at an emergency department or other site where emergency medical services are provided where a determination is made by a healthcare professional of medical urgency of wounds or illness to decide the order of treatment for patients.

Vendor means an individual or company that sells goods or services on an ongoing basis at a healthcare or social assistance establishment.

Violent Incident Log means the systematic and ongoing documentation of each incident reported through the violent incident reporting system.

Violent Incident Report and *Violent Incident Reporting System* mean the individual report filed in response to a violent incident and the system implemented by the employer to collect the details of each report, respectively.

Workplace violence incident means any violent act (including physical assault and threat of physical assault) directed toward persons at work or on duty by patients or their visitors. It may or may not result in injury.

Workplace violence response team means a group of employees designated to respond to violent incidents. They have advanced levels of training and do not have other assignments that would prevent them from responding immediately to an alarm to assist other staff.

Work practice controls mean policies and procedures that reduce the likelihood of workplace hazards. These controls include maintaining sufficient staff for the hazard, and providing training on de-escalation techniques and how to respond to workplace violence.

(c) Workplace Violence Prevention Program (WVPP).

(1) *General*. Each employer must develop, implement, and maintain a written workplace violence prevention program (WVPP).

(2) *Elements of the WVPP*. The WVPP must contain at least the following elements:

(i) A copy of the workplace hazard assessment as required in paragraph (d), Table E-1, or Table E-2, as applicable.

(ii) All standard operating procedures associated with the development and implementation of workplace violence control measures to address identified workplace violence hazards or risk factors as required in paragraph (e), Table E-1, or Table E-2, including written records of controls implemented, as applicable.

(iii) All standard operating procedures and policies associated with recording, reporting, and investigating violent incidents as required in paragraph (g).

(iv) A copy of the employer's anti-retaliation policy, as required in paragraph (i).

(v) Procedures to effectively communicate and coordinate with other employers at the same

worksite:

(A) Host employers must include a description of procedures to protect employers on-site (e.g. contractors, vendors, staffing agencies, and licensed independent practitioners with privileges) from workplace violence hazards.

(B) The host employer must ensure that other employers on-site adhere to the host employer's WVPP.

(C) The host employer must establish procedures to facilitate communication regarding the implementation of the WVPP between the host employer and other employers on-site.

(D) Other employers on a multi-employer worksite must include a description of how their WVPP coordinates with that of the host employer.

(vi) Procedures to involve non-managerial employees and their representatives (if applicable) in developing, implementing, and reviewing the WVPP, including their participation in:

(A) Identifying, evaluating, and correcting workplace violence hazards;

(B) Designing and implementing training and reporting procedures;

(C) Investigating workplace violence incidents; and

(D) Annually reviewing the WVPP.

(vii) The names and job title of the designated program administrator.

(3) *Review of the WVPP.* The WVPP must be reviewed and updated at least annually and whenever necessary to reflect changes in the workplace, including a change in population, services provided, or the investigation of violent incidents, that indicate a need to revise policies to address employee exposure to workplace violence.

(i) The program review must be conducted by a team consisting of management, non-managerial employees, and their employee representatives (if applicable).

(ii) Employers must establish and maintain written records for each review and/or update of the WVPP.

(iii) The team must evaluate records and information pertaining to the implementation and effectiveness of the WVPP.

(4) *Employee Involvement.* Employers must allow sufficient paid time for employees to complete any required WVPP activities (e.g., training, reporting, incident reviews, etc.) at a reasonable time and location.

(5) Employers must notify all employees of the existence and contents of the WVPP, how to report violent incidents, and whom to contact with questions via postings in areas accessible to all employees.

(d) Workplace violence hazard assessment.

(1) Assessment of risk factors throughout the establishment. Each employer must conduct an assessment to identify environmental and organizational risk factors throughout the establishment. The employer must:

(i) Provide an opportunity for employees to report all workplace violence incidents that occurred in the establishment in the previous three years.

(ii) Record all previously unreported workplace violence incidents in the establishment in the previous three years.

(iii) Review all workplace violence incidents in the establishment in the previous three years.

(iv) Evaluate employee risk for workplace violence based on the level and types of crime in the employer's served community.

(v) Assess all areas of the establishment for the following risk factors:

(A) Employees with direct patient/client/resident care or contact duties working alone or in remote locations, or during night or early morning hours;

(B) Locations within the establishment without emergency communication, such as areas where alarm systems are not installed or operational, or where any obstacles and impediments to accessing alarm systems may exist; and

(C) Ineffective communication mechanisms or practices regarding patient/client/resident status between shifts and between personnel.

(vi) In addition to the hazards and risk factors in (d)(1)(v), at a minimum, the employer must assess all high-risk service areas, as defined in paragraph (b) for the following risk factors:

(A) Poor illumination or areas with blocked or limited visibility;

(B) Employee staffing patterns that are inadequate to reduce workplace violence or respond to workplace violence incidents;

(C) Lack of physical barrier protection between employees and patients/visitors in areas such as admission, triage, and nursing stations;

(D) Lack of effective escape routes;

(E) Entryways where unauthorized entrance may occur, such as doors designated for staff entrance or emergency exits; and

(F) Presence of unsecured furnishings or other objects that could be used as weapons.

(2) Each employer must establish and implement effective procedures to address the findings from the hazard assessments, and maintain written records of the hazard assessments. These procedures must include:

(i) Identification of high-risk service area(s);

(ii) Identification of specific hazards or risk factors;

(iii) A plan to abate the identified hazards or risk factors in an immediate or timely manner during the interim of more permanent abatement;

(iv) Date(s) the assessment was performed;

(v) The names and titles of the individuals who participated in the evaluation;

(vi) Actions planned to address and prioritize mitigation of identified hazards or risk factors permanently;

(vii) Communication of the status of planned or completed actions to employees who may be affected by the identified hazards or risk factors;

(viii) The dates by which planned actions are to be completed;

(ix) Written documentation of completed actions including:
(A) The method(s) of control decided upon;
(B) Areas where controls were implemented;
(C) Specific date(s) of completion; and
(D) The names and titles of the individuals who authorized and managed implementation of controls.
(x) Records of workplace violence hazard identification, evaluation, and correction must be created and maintained for three years, or for as long as there is an unresolved hazard mitigation project pending or still in progress.

(3) Annual hazard assessments. Each employer must conduct subsequent hazard assessments annually as described in subsection (d)(1).

(4) Additional hazard assessments. Each employer must conduct subsequent area-specific hazard assessments in response to:
(i) Workplace violence incidents as specified in paragraph (g)(3)(ii);
(ii) Physical changes in the layout, design, or amenities of the workplace that could increase the risk of workplace violence; or
(iii) Changes in clientele or services provided that could increase the risk of workplace violence.

(5) Multi-employer worksites.
(i) The host employer must conduct the hazard assessment for the establishment.
(ii) Other employers on a multi-employer worksite who work in a high-risk area must coordinate with the host employer to provide any information requested by the host employer in order to comply with Paragraph (d).

(6) Home Healthcare and Field-Based Social Assistance Services. Paragraphs (d)(1)-(d)(5) do not apply to home healthcare and field-based social assistance service employers, emergency medical services employers, or staffing agencies. These employers must complete the assessments in Table E-1 for Home Healthcare and Field-Based Social Assistance Services, or Table E-2 for Emergency Medical Services, as incorporated in paragraph (e)(6).

(e) Control measures.

(1) Based on the hazard assessments, the employer must establish and implement workplace violence control measures to address identified workplace violence hazards or risk factors. Each employer must:

(i) Install, implement, and maintain the use of an effective alarm system for use by employees with direct patient/client/resident care or direct patient/client/resident contact duties.

(ii) Establish and implement effective workplace violence incident response procedures that include, as applicable:

(A) Standard operating procedures for employees with direct patient care/client care or direct patient/client/resident contact to summon help during a workplace violence incident.

(B) Standard operating procedures for receiving patients/clients/residents who are actively exhibiting violent behavior, including those escorted by law enforcement officers;

(C) Standard operating procedures for staff designated to respond to workplace violence incidents;

(D) If employer uses restraint methods, standard operating procedures for the appropriate use of restraints in accordance with federal, state, and local laws, and ensuring the availability of needed physical and pharmacological restraints, and/or seclusion procedures for high-risk services.

(E) Standard operating procedures to respond to mass casualty threats, such as active shooters; and

(F) Standard operating procedures for obtaining assistance from the appropriate law enforcement agency during all work shifts.

(iii) Establish and implement policies and procedures for employees to document and communicate patient/client/resident specific risk factors to other employees, such as when transporting or receiving patients/clients/residents, and during handoffs between shifts and units. At a minimum, policies and procedures must include:

(A) A patient/client/resident's prior history of violence, to the extent that such history is known to the employer or can be determined by records within the employer's possession;

(B) Any conditions that may cause the patient/client/resident to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively;

(C) Any recent disruptive or threatening behavior displayed by a patient/client/resident; and

(D) Effective communication via flagging and visible cues of a patient/client/resident's history or potential for violence on patient charts or client case history for all relevant staff.

(E) For those employees providing direct patient/client/resident/resident care, a patient/client/resident's treatment and medications, type, and dosage, as is known to the health establishment and employees.

(iv) Establish and implement policies and procedures for effective communication of a patient/client/resident's history or potential for violence to all subsequent external healthcare employers that a patient may be referred to.

(2) Based on the hazard assessment, the employer must implement engineering controls to address identified workplace violence hazards or risk factors in high-risk service areas. At a

minimum, engineering controls must:

(i) Ensure that employees have a clear line of sight in public areas of the establishment, including waiting rooms and hallways, so that employees can observe all activities in areas where members of the public are moving through care or service areas from their work stations without impediment by room design, furniture, and/or other objects. This includes:

(A) Ensuring no obstructions to line of sight exist;
(B) Ensuring sufficient illumination;
(C) Installing surveillance systems or other sight aids such as mirrors;
(D) Other effective means.

(ii) Ensure that employees have unobstructed access to alarms and exit doors as a means to escape violent incidents.

(iii) Remove, fasten, or secure furnishings and other objects that may be used as improvised weapons in areas where direct patient/client/resident contact/care activities are performed.
(iv) Install protective barriers between employees and patients/visitors in areas such as admission, triage, and nursing stations.
(v) An employer need not implement one of these engineering controls to address the hazard in a particular area if the employer has demonstrated in writing as part of its hazard assessment that the control is not appropriate or feasible for that area.

(3) Additional work practice controls must be implemented in high-risk service areas. At a minimum, work practice controls must include:

(i) Installing, implementing, and maintaining the use of personal panic alarms or other effective means of automated personal emergency communication for employees with direct patient care/direct patient contact duties in high-risk service areas.
(ii) Creating a security policy to address:

(A) The movement of authorized and unauthorized persons into and throughout the establishment; and
(B) The movement of authorized and unauthorized weapons into and throughout the establishment.

(iii) Maintaining staff designated to immediately respond to workplace violence incidents in high-risk service areas.
(iv) Ensuring that staffing patterns are sufficient to address the workplace violence hazard. Staffing patterns must account for changes, including: intensity of patients' needs; the number of admissions, discharges and transfers during a shift; level of experience of nursing staff; layout of the unit; and availability of resources (ancillary staff, technology etc.).
(v) An employer need not implement one of these work practice controls to address a hazard if it demonstrates in writing that the control is not appropriate or feasible for that area.

(4) The employer must provide appropriate personal protective equipment (PPE) such as bite-resistant sleeves or protective facewear at no cost to the employees.

(5) Multi-employer worksites. On multi-employer worksites the host employer must establish and implement all workplace violence control measures.

(6) Home Healthcare and Field-Based Social Assistance Services. Paragraphs (e)(1)—(e)(5) do not apply to home healthcare and field-based social assistance service employers, emergency medical services employers, or staffing agencies. These employers must implement the control measures in Table E-1 for Home Healthcare and Field-Based Social Assistance Services, or Table E-2 for Emergency Medical Services.

TABLE E-1: Home Healthcare and Field-Based Social Assistance Services – Workplace Assessment and Control Measures

At a minimum, known risk factors to be assessed annually and control methods include:		
	Assessment	**Control Methods**
(i)	Each employer must: (a) Review all workplace violence incidents within the previous three years; (b) Provide an opportunity for employees to report previously unreported incidents and threats of physical harm, regardless of whether an employee sustained an injury; and (c) Conduct an evaluation of any work practice controls or personal protective equipment implemented to minimize workplace violence hazards.	Based on the review of incidents, the employer must establish and implement the following workplace violence control measures: (a) Standard operating procedures for incident response; (b) Standard operating procedures for obtaining assistance from the appropriate law enforcement agency; (c) Policies and procedures for employees to document and communicate patient/client/resident specific risk factors to other employees, such as during handoffs between shifts; and (d) Provision of personal protective equipment as appropriate.
(ii)	Employer must assess the adequacy of two-way personal emergency communications devices that can be used by employees to summon aid when working alone with patients/clients/residents.	Employer must provide all employees with working personal emergency communications devices that can be used by employees to summon aid, e.g., cell phones equipped with emergency applications, two-way radios, wearable safety communication devices, etc.
(iii)	Employer must assess the level and types of crime in the community where services are being provided.	Employer must communicate this information related to the potential for violence in the surrounding community to each employee prior to the employee's first visit.
(iv)	Employer must assess the efficacy of its procedures for collecting information concerning	Employer must establish and implement procedures for obtaining and communicating to employees any information concerning a

	patients'/clients' history of violence and the history of violence of anyone else in the household, and the employer's procedures to provide that information to employees prior to the first visit.	history of violence by the patient/client/resident or anyone else in the household prior to an employee's first visit. The employer must document this information in the patient/client/resident's chart and update the employee if there is any change in status.
(v)	Employer must assess whether a clear written safety policy exists to indicate the parameters for an employee to provide services in the presence of potentially violent patients/clients/residents or others. Employer must evaluate whether the policy indicates parameters for when to continue the care visit, summon immediate assistance, or discontinue the visit.	Employer must establish clear, written policies for what employees should do if they feel unsafe, e.g., due to aggressive patients/clients/residents or others in the household. Policies must include when an employee should call for assistance or terminate the visit.
(vi)	The employer must evaluate and maintain written records of the review of workplace violence incidents.	The employer must create and maintain written records of workplace violence control measures implemented. Written documentation of the controls implemented must include: (a) The methods of control decided upon; (b) Area(s) where controls were implemented; (c) Date(s) by which the controls will be implemented; (d) Dates that the controls were implemented; and (e) The names and titles of the individuals who authorized implementation of controls. These records must be created and maintained for three years, or for so long as there is an unresolved hazard mitigation project pending or still in progress.
(vii)	An employer need not implement one of these workplace violence control measures to address the hazard in a particular area where the employer has demonstrated in writing as part of its review of workplace violence incidents that it is not appropriate or feasible.	

TABLE E-2: Emergency Medical Services –
Workplace Assessment and Control Measures

At a minimum, known risk factors to be assessed annually and control methods include:		
	Assessment	**Control Methods**
(i)	Each employer must: (a) Review all workplace violence incidents within the previous three years; (b) Provide an opportunity for employees to report previously unreported incidents and threats of physical harm, regardless of whether an employee sustained an injury; and (c) Conduct an evaluation of any engineering controls, work practice controls, or personal protective equipment implemented to minimize workplace violence hazards.	Based on the review of incidents, the employer must establish and implement the following: (a) Standard operating procedures for incident response; (b) Standard operating procedures for obtaining assistance from the appropriate law enforcement agency; (c) Policies and procedures for employees to document and communicate patient/client/resident specific risk factors to other employees; and (d) Provision of personal protective equipment as appropriate.
(ii)	Review procedures for obtaining and communicating information regarding environmental risk factors and patient/client/resident risk factors.	Develop procedures for communicating with dispatching authorities to identify any risk factors present at the scene and ensure that appropriate assistance will be provided by cooperating agencies if needed.
(iii)	Employer must assess the adequacy of two-way personal emergency communications devices that can be used by employees to summon aid when working with patients/clients/residents.	Employer must provide all employees with working personal emergency communications devices that can be used by employees to summon aid, e.g., cell phones equipped with emergency applications, two-way radios, wearable safety communication devices, etc.
(iv)	The employer must evaluate and maintain written records of the review of workplace violence incidents.	The employer must create and maintain written records of controls implemented. Written documentation of the controls implemented must include: (a) The methods of control decided upon; (b) Area(s) where controls were implemented (c) Date(s) by which the controls will be implemented; (d) Dates that the controls were implemented; and (e) The names and titles of the individuals who authorized implementation of controls. These records must be created and maintained for three years, or for so long as there is an unresolved hazard mitigation project pending or still in progress.
(v)	An employer need not implement one of these workplace violence control measures to address the hazard in a particular area if the employer has demonstrated in writing as part of its review of workplace violence incidents that it is not appropriate or feasible.	

(f) Training.

(1) The employer must institute a training program for employees, who have direct patient/client/resident contact, provide direct patient/client/resident care, or are responsible for workplace violence incident response duties, and their supervisory staff. Training must be provided to these employees at the following intervals:

(i) Initially, prior to the time of assignment, or when newly assigned to perform duties for which the training required in this subsection was not previously provided;

(A) If an employee received workplace violence prevention training from the employer in the 12 months preceding the effective date of this standard, the employer need only provide additional training to the extent that the previous training did not meet the requirements of this standard;

(ii) Annually thereafter; and

(iii) Supplemental training to address specific deficiencies when:

(A) There are changes to any procedures or controls designed to address workplace violence. This training may be limited to addressing only these changes;

(B) Inadequacies in the employee's knowledge or work practices indicate that the employee has not retained the requisite understanding or skill; or

(C) Any other situation that arises in which retraining is necessary to ensure employee protection from workplace violence.

(2) The training program must:

(i) Be overseen or conducted by a person knowledgeable in the program's subject matter as it relates to the workplace;

(ii) Consist of material appropriate in content and vocabulary to the educational level, literacy, and language of employees;

(iii) Be provided at no cost to employees at a reasonable time and place; and

(iv) Provide an opportunity for interactive questions and answers with a person knowledgeable in the program's subject matter as it relates to the workplace.

(3) The initial training program must contain content that reflects the level of risk to employees and the duties that they are expected to perform. At a minimum, training for employees with direct patient/client/resident contact duties and their supervisors must contain an introductory/awareness level of instruction on the following elements:

(i) An accessible copy of this standard and an explanation of its contents;

(ii) A general explanation of the risks of workplace violence that employees are reasonably anticipated to encounter in their jobs;

(iii) How to recognize, initiate and respond to specific alerts, alarms, or other warnings about threats of workplace violence;

(iv) The role of security personnel, if any;

(v) How and under which circumstances to report workplace violence incidents to

law enforcement;

(vi) An explanation of the employer's violent incident reporting system and its anti-retaliatory policy;

(vii) Any resources available to employees for coping with workplace violence incidents, such as employee assistance programs;

(viii) Training on all of the standard operating procedures developed as part of the WVPP that are applicable to the employee's duties;

(ix) Instruction on the use of employer-provided equipment including alarms, communication devices, and personal protective equipment, as well as the limitations of this equipment;

(x) How to recognize threatening behaviors in others, techniques for when and how to safely attempt to de-escalate a violent situation; and

(xi) When and how to seek assistance to respond to potentially escalating violence.

(4) At a minimum, initial training for employees with direct patient/client/resident care duties in areas other than high-risk service areas, and their supervisors, must contain an intermediate level of instruction on the content specified in (f)(3), in addition to:

(i) An introduction to self-defense strategies and techniques; and

(ii) How and when to assist others engaged with a violent patient/client/resident or visitor.

(5) At a minimum, initial training for employees with direct patient/client/resident care duties in high-risk service areas, and their supervisors, must contain an intermediate level of instruction on the content specified in (f)(3) and (f)(4), as well as an explanation of the policies and procedures for workplace violence incidents, as well as the demonstration of practical techniques for using them.

(6) Initial training for employees designated to respond to a violent incident and their supervisors, must contain an advanced level of instruction with all elements listed in (f)(3), (f)(4), and (f)(5) and all standard operating procedures that are applicable to the response team, or individual responders, as applicable.

(7) The annual training program must address, at a minimum, the following elements:

(i) Training on all of the standard operating procedures developed as part of the WVPP that are applicable to the employee's duties, including any changes to the program that have been made in the past year;

(ii) An explanation of the employer's violent incident reporting system, including any changes to the system that have been made in the past year, and results of the review(s) required in subsection (c)(3);

(iii) Any resources available to employees for coping with workplace violence incidents, such as employee assistance programs; and

(iv) Employees who received practical training on physical techniques and those employees' supervisors shall be provided refresher training to review the topics included in the initial training.

(8) Training records must be created and maintained for a minimum of one year and include training dates, course contents or a summary of the training sessions, names and qualifications of persons conducting the training, and names and job titles of all persons attending the training sessions.

(g) Violent incident investigation and recordkeeping.

(1) The employer must implement and maintain a written violent incident reporting system for employees to report each workplace violence incident. The violent incident reporting system must include at least the following:

(i) Procedures for employees to promptly report a violent incident, threat of physical harm, or the existence of other workplace violence hazards; and

(ii) Policies and procedures that prohibit the employer, or any other person, from discriminating or retaliating against an employee who reports a workplace violence incident.

(2) Violent Incident Investigation. The employer must establish procedures to investigate the circumstances surrounding each workplace violence incident and obtain information from the employee(s) who experienced or observed the incident.

(i) The employer must initiate an investigation as soon as practicable, but no later than 24 hours after notification that a workplace violence incident has occurred. The employer must conduct an investigation of each incident that includes at least the following:

(A) Review of the circumstances of the incident;

(B) Determination of whether any controls or measures implemented pursuant to the WVPP were ineffective;

(C) Determination of whether additional measures could have prevented the incident;(D) Determination of whether there is a continuing hazard, and if so, what measures are being taken to protect employees, using modifications of engineering controls, work practice controls, training, or other measures; and

(E) Solicitation of input from involved employees, their representatives (if applicable), and supervisors, about any significant contributing factors to the incident, risk, or hazard, and whether further corrective measures could have prevented the incident, risk, or hazard.

(ii) The employer must document the significant contributing factors, recommendations, and corrective measures taken for each investigation conducted under this paragraph, and incorporate into the annual hazard assessment as required in (d)(4), Table E-1, or Table E-2, as applicable.

(3) Following a workplace violence incident in a service area or activity not previously identified as high-risk, the employer must assess the service area at issue and job functions or activities that may have placed employees at increased risk for workplace violence.

(i) Any service area with a workplace violence incident should be considered high-risk unless there is a written determination of why this designation is not appropriate.
(ii)When a service area is newly-determined to be high-risk, the employer must conduct an reassessment of the area consistent with the assessment in paragraphs (d)(1)(iv) and implement the controls identified in (e)(2) through (e)(3). The assessment must be conducted within 30 days unless the employer demonstrates it is infeasible, in which case it must be completed as soon as possible.

(4) Violent incident log: The employer must establish and maintain records of each workplace violence incident, by establishment or by relevant patient/client/resident care unit, regardless of whether the incident meets the criteria for an OSHA recordable injury or illness under 29 CFR Part 1904.

(i) Multi-employer worksites. The host employer must record violent incidents affecting any contractors, vendors, staffing agencies, and licensed independent practitioners with privileges operating in the establishment.

(ii) The violent incident log must include, at a minimum:

(A) Employee's name(s);
(B) Hire date(s);
(C) The date, time, and location of the incident, and job titles of involved employee(s);
(D) A detailed description of the incident;
(E) A description of risk factors present at the time of the incident (e.g., whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, in a high crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances);
(F) The nature and extent of the employee's injuries, if any;
(G) Whether the incident required medical attention;
(H) Whether there was injury requiring days away from work;
(I) Name of person(s) who committed the violence;
(J) Classification of the person(s) who committed the violence, including whether they were a patient or client, family member or associate of a patient or client, or any other appropriate classification; and
(K) Information about the person completing the log including their name, job title, phone number, email address, and the date completed.

(iii) The following information from the violent incident log must be available upon request to all employees:

(A) The nature and extent of the employee's injuries, if any;
(B) A detailed description of the incident;
(C) The date, time, and location of the incident, and job titles of involved employee(s); and
(D) A description of risk factors or other circumstances at the time of the incident.
(E) Classification of the person(s) who committed the violence, including whether they were a patient or client, family member or associate of a patient or client, or

any other appropriate classification.

(F) This information relating to employee health must be used in a manner that protects the confidentiality of employees to the extent possible. The employer must omit any element of personal identifying information sufficient to allow identification of any person involved in a workplace violence incident, such as the person's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the person's identity.

(h) Retention of records.

(1) Access to records. All records required by this section shall be provided upon request to employees, representatives designated by an individual employee, and the Assistant Secretary within the next business day.

(i) Records of annual WVPP reviews as required by paragraph (c) must be created and maintained for a minimum of three years.

(ii) Records of workplace violence hazard assessment and control measures as required in paragraphs (d) and (e), Table E-1, or Table E-2, as applicable, must be created and maintained for three years, or for as long as there is an unresolved hazard mitigation project pending or still in progress.

(iii) Training records as required in paragraph (f) must be created and maintained for a minimum of one year.

(iv) Records of violent incidents, including violent incident investigation reports and violent incident log reports required by this paragraph must be created and maintained for a minimum of three years.

(A) Establishment-wide violent incident records shall be provided to the Assistant Secretary upon request.

(B) Establishment-wide violent incident log reports, excluding employee names, contact information, and occupations, shall be provided to all of the following: any employees, their personal representatives, and their authorized representatives.

(C) Violent incident records relating to a particular employee shall be provided to that employee and to anyone having written authorized consent of that employee.

(Note to paragraph (h)*: The violent incident investigation reports and violent incident logs shall not replace the employer's obligations to comply with 29 CFR Part 1904. Injuries or illnesses that occur as a result of* ***workplace violence*** *may be recordable on the* ***OSHA*** *300 log*.)

(i) Anti-retaliation.

(1) The employer must inform each employee that:

(i) employees have a right to the protections required by this section; and

(ii) employers are prohibited from discharging or in any manner discriminating against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.

(2) The employer must not discharge or in any manner discriminate against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.

Note to paragraph (i): In addition, section 11(c) of the OSH Act also prohibits the employer from discriminating against an employee for exercising rights under, or as a result of actions that are required by, this section. That provision of the Act also protects the employee who files a safety and health complaint, or otherwise exercises any rights afforded by the OSH Act.

(j). Effective Date of the Standard. (1) All the provisions of the final standard will become effective sixty days after the publication date of the final standard.

(2) Employers shall comply with all provisions of the final standard within six months after the publication date of the final standard.

Section IV-b. Summary of the Draft Regulatory Text for Prevention of Workplace Violence in Healthcare and Social Assistance

OSHA has developed the following summary of the draft regulatory text for a workplace violence prevention rule, which explains OSHA's current thinking on the elements that a proposed rule may contain. As described earlier, the regulatory text included is a draft to provide descriptive information and to solicit feedback from small entity representatives. All references made to regulatory text are addressing this working draft.

(a) Scope.

Paragraph (a) of the draft regulatory text covers the scope of the draft rule. The evidence that OSHA has reviewed so far suggests that healthcare and social assistance service workers face significant risks of job-related violence. Workplace violence affects a myriad of healthcare and social assistance workplaces, including psychiatric facilities, hospitals, emergency departments, community mental health clinics, ambulatory substance abuse treatment centers, residential care facilities, home healthcare, and emergency medical services (EMS).
In order to prevent incidents of workplace violence in healthcare and social assistance settings, the draft regulatory text would cover all employers with employees who work in:

- Hospitals, including emergency departments;
- Psychiatric hospitals and residential behavioral health facilities;
- Ambulatory mental health care and ambulatory substance abuse treatment centers;
- Freestanding emergency centers;
- Residential care facilities;
- Home health care;
- Emergency medical services (including firefighters cross-trained to provide emergency medical services); and
- Social assistance (excluding child day care centers).

OSHA recognizes that the social assistance sector includes a broad spectrum of employers. Employers in this sector may provide individual and family services from a fixed location such as service center or a hospital, or also in patient/client/resident homes or another off-site location. Social assistance employers that provide services in a fixed establishment may operate their own centers or shelters, or they may subsidize housing used for clients in need. There are a wide variety of employers and services provided within the social assistance sector, and OSHA seeks to engage with SBAR panel participants to better identify and understand the employers in this sector, the services they provide, and the areas where violence prevention programs could be most effective.

All employers with employees who work in facilities as described in the scope of this draft rule would have to develop, implement, and maintain a written workplace violence prevention

program (*see* paragraph (c)), conduct a hazard assessment (*see* paragraph (d)), implement control measures (*see* paragraph (e)), provide training (*see* paragraph (f)), investigate workplace violence incidents and maintain records (*see* paragraphs (g) and (h)). The agency has chosen the sectors listed above because OSHA's experience, BLS data, and the best available epidemiological literature consistently demonstrate that the sectors described above have the highest potential risk for workplace violence. OSHA welcomes feedback from the Small Entity Representatives (SERs) on the draft scope of the standard.

(b) Definitions.

Paragraph (b) of the draft regulatory text covers the draft rule's definitions. OSHA has determined that employees most at risk of workplace violence are those performing healthcare services or social assistance services with hands-on or face-to-face contact with patients (defined as "direct patient/client/resident care" in paragraph (b) of the draft regulatory text). They include nurses, physicians, and other healthcare workers, social workers visiting client homes, as well as employees providing emergency medical services.

Employees who perform support work that requires them to be in patient/client/resident care areas (defined as "direct patient/client/resident contact" in paragraph (b) of the draft regulatory text) are also at risk. This work includes housekeeping, maintenance, meal delivery, and information technology. For purposes of SBREFA, OSHA also considers security staff to belong in this category. Each covered employer would need to determine whether employees provide direct patient/client/resident care, have direct patient/client/resident contact, have workplace violence incident response duties, or supervise such staff. These duties are relevant to the type of training that is needed (*see* paragraph (f)).

While security guards supporting healthcare or social services may also have significant exposure to patients during a response to an incidence of violence in a manner that increases the risk of injury because of the type of interaction, the draft standard does not group them with the direct care providers that are also at high-risk. Security guards are grouped with the "contact" group of employees. OSHA expects security guards to be trained effectively by their employers on the proper response to violent incidents because those incidents constitute a recognized hazard of that type of employment and part of the function of those employees is to resolve those incidents.

For discussion's sake OSHA estimated how injuries are distributed between patient/client resident care employees, patient/client/resident contact employees, and other employees in the healthcare in social assistance sectors. Upon review of BLS Special Run Data for Number of WPV Injuries by Occupation within healthcare and social assistance OSHA found, that, in 2019:

- Patient/Client/Resident Care Employees accounted for 78 percent of WPV injuries;

- Patient/Client/Resident Contact Employees accounted for 20 percent of WPV injuries; and

- All other occupations in healthcare and social assistance accounted for 2 percent of WPV injuries.

OSHA notes that BLS data are not broken down so neatly as to provide precise numbers to work with, but for discussion's sake during this SBREFA process, these may be reasonable estimates to work with. (BLS Special Run Data for Number of WPV Injuries by Occupation within Healthcare and Social Assistance, 2019)

This draft standard is focused on controls and other prevention measures for workers engaged in healthcare or social services who, absent this standard, may not be properly trained or protected from workplace violence incidents. OSHA requests feedback from SERs regarding whether security personnel should be subject to additional protections under this standard and, if so, what types of protections. In particular, OSHA requests additional information about the function of security services contracted by healthcare or social service employers and their expected involvement in responses to incidents of workplace violence.

The draft standard requires employers to assess "high-risk service areas" (*see* paragraph (d)) and implement controls in those areas (*see* paragraph (e)). "High-risk service area" means settings where there is an elevated risk of workplace violence, and includes emergency rooms/emergency admissions/triage areas, psychiatric care, behavioral healthcare, substance abuse treatment, home healthcare social assistance, and emergency medical services. It also includes an area where a workplace violence incident has occurred in the previous three years unless the employer provides a written determination of why this designation is not appropriate.

The draft regulatory text defines workplace violence incident as "any violent act (including physical assault and threat of physical assault) directed toward persons at work or on duty by patients or their visitors. It may or may not result in injury." Like the National Institute for Occupational Safety and Health (NIOSH), OSHA has long considered threats of violence to constitute workplace violence due the potential for physical harm.

The draft standard covers employers that directly control their employees' workplace as well as employers (such as contractors, vendors, and staffing agencies) that have employees who work in a covered sector, even if they do not directly control their employees' workplace. The draft standard defines "host employer" as an employer that owns, operates, or controls the operation of a fixed-establishment work setting (e.g., hospital, behavioral health center). "Vendor" means an individual or company that sells goods or services on an ongoing basis at a healthcare or social assistance establishment. For example, a hospital may be staffed completely with its own employees or it may contract out certain departments (e.g., an emergency department staffed

with employees from a staffing agency), other services (e.g., environmental services staff, transportation services, or security staff provided by a contractor), as well as perhaps vendors at certain sites (e.g. gifts, sundries, florists, and public food services).

(c) Workplace Violence Prevention Program (WVPP).

Paragraph (c) of the draft standard requires each employer to develop, implement, and maintain a written workplace violence prevention program. This would be a program-oriented standard, which would allow the employer to tailor the specific regulatory requirements to their own establishment, while not eliminating any items when converting to their own use. The program would be required to contain all elements required by the WVPP, but can be written and implemented in a way that employers and their employees can best suit to their workplace. Employers would have the flexibility to tailor the plan and its implementation to specific workplace conditions and hazards. OSHA has enacted other program standards for healthcare industries in the past, such as the Bloodborne Pathogens standard, 29 C.F.R. § 1910.1030, and the Respiratory Protection standard, 29 C.F.R. § 1910.134. Eleven states also require healthcare employers to develop and implement a workplace violence prevention plan.

The plan would be in effect at all times and be specific to the hazards and any corrective measures associated with those hazards for each establishment. A written plan is necessary to allow employees working on all shifts to refer to procedures that must be followed for optimal prevention and response to incidents of workplace violence. The requirements of the WVPP would allow the written plan to be incorporated into any existing injury and illness prevention program that the employer may already have in place, or to be kept as a separate standalone document.

The WVPP would focus on developing processes and procedures appropriate and specific for the size and complexity of the specific establishment's operation or work setting. OSHA expects that a written program for workplace violence prevention can offer an important component of an effective approach to reduce or eliminate the risk of violence in the workplace. Having the WVPP in written form is essential to ensuring components of the plan have been effectively implemented. Establishing policies for the WVPP ensures the reporting, recording, and monitoring of incidents. Employers would be required to notify all employees of the existence of the WVPP, how to report violent incidents, and whom to contact with questions via postings in areas accessible to all employees.

Paragraph (c)(2) identifies the specific elements that OSHA requires in the WVPP. Paragraph (c)(2)(i) specifies that the WVPP contain a copy of the workplace violence hazard assessment, including all identified high-risk areas and activities and a review of all incidents of workplace violence that have occurred in the establishment, service or site of care within the past three years (whether or not an injury occurred). The specific requirements for hazard assessments for

home healthcare and emergency medical services are described in additional detail in discussions of paragraph (e) Control Measures, Table E-1 for Home Healthcare and Field-Based Social Assistance Services--Workplace Assessment and Control Measures, or Table E-2 for Emergency Medical Services--Workplace Assessment and Control Measures, as applicable.

Paragraph (c)(2)(ii) would require the WVPP to include all standard operating procedures (SOPs) associated with the development and implementation of workplace violence control measures to address identified workplace violence hazards or risk factors, including written records of controls implemented (if applicable). More specific requirements for these control procedures for home healthcare and emergency medical services are described in additional detail in discussions of paragraph (e) – Control Measures, Table E-1: Home Healthcare and Field-Based Social Assistance Services, or Table E-2: Emergency Medical Services, as applicable.

Paragraphs (c)(2)(iii) and (iv) of this draft standard specify that the WVPP must include all SOPs associated with recording, reporting and/or investigating violent incidents as required in *paragraph (g)* - Violent Incident Investigation and Recordkeeping. These SOPs could include, for example: how employees will document and communicate information regarding conditions that may increase the potential for workplace violence incidents to other employees and between shifts and units; how an employee can report a violent incident, threat, or other workplace violence concern; how employees can communicate workplace violence concerns without fear of reprisal; how employee concerns will be investigated, and how employees will be informed of the results of the investigation and any corrective actions to be taken. Assuring personnel that an individual can report a potential workplace violence problem without fear of reprisal would remove barriers to identifying problematic and possibly dangerous situations as they arise in the workplace (further discussion on this is presented later in discussion of paragraph (g)- Violent Incident Investigation and Recordkeeping, and paragraph (i) Anti-Retaliation).

Paragraph (c)(2)(v) requires employers to develop procedures to communicate and coordinate their WVPP with other employers at the same worksite. This is a topic for which OSHA is particularly interested in engaging with SERs on how multi-employer worksites currently coordinate their workplace violence prevention and other safety and health efforts. OSHA is also interested in SERs' perspectives on whether and how multi-employer duties and responsibilities should be specified in a rule.

The draft regulatory text requires communication and coordination between the host employer and any contractors, vendors, staffing agencies, and licensed independent practitioners with privileges. Host employers would be required to include a description of the procedures to protect other employers on the worksite from workplace violence, ensure that other employers on-site adhere to the host employer's WVPP, and establish procedures to facilitate

communication. In turn, other employers on a multi-employer worksite would provide to the host employer a description of how their WVPP coordinates with that of the host employer. This collaborative effort could ensure that these requirements are fully-met in a way that is least burdensome to all employers and most protective of the safety and health of the workers.

Paragraph (c)(2)(vi)(A) and (B) outline requirements for employers to develop procedures for involving non-managerial employees and their representatives (if necessary) in developing and implementing the WVPP. This includes involvement with identifying, evaluating, and correcting workplace violence hazards. It also includes the design and implementation of training and reporting procedures. The WVPP would include the employer's written procedures for providing training to all covered employees. This element emphasizes training on potential violence that these employees in specific units or operations are actually exposed to. This approach focuses on necessary information and minimizes wasted employee time. Further information on the subject of training is provided in the description of *paragraph (f)-Training* in this document.

Under paragraphs (c)(2)(vi)(C) and (D), employers would also be expected to involve non-managerial employees in the investigation of workplace violence incidents, as well as in the review of the WVPP. OSHA expects that employees involved in the investigation may include non-managerial employees as well as employees from security services, environmental services, occupational safety and health, human resources, medical staff, and social services, and/or others, as relevant.

Although management is responsible for controlling hazards, employees have a critical role to play in helping to identify and assess workplace hazards. Non-supervisory employees have knowledge and familiarity with the operation of the establishment, process activities and potential threats. Active involvement of all employees, particularly non-managerial workers, is necessary for an effective WVPP. OSHA believes that management leadership and employee participation are critical elements for an effective WVPP. The active involvement of employees can be critical in identifying, evaluating, and correcting workplace violence hazards, and in the design and implementation of training, reporting procedures, investigation of workplace violence incidents, and periodic review of the WVPP. Employees with different job functions and at various organizational levels should be included so that they bring a broad range of experience and skills to program design, implementation, and assessment.

Paragraph (c)(2)(vii) would require that the name and job title of the designated program administrator be included in the WVPP. The program administrator is the person(s) responsible for providing logistical oversight and coordinating and managing administrative and technical oversight of all elements of the WVPP. OSHA believes that there needs to be one individual named as the primary program administrator for the WVPP, along with the names and job titles of persons responsible for implementing the program. This individual may be an employee of the

establishment or contracted by the establishment to meet the obligations of the program. This draft rule would require that, if the designated program administrator does not have the knowledge, skills, or training necessary to implement and oversee the program effectively, then they would be required to consult with appropriate personnel who have such knowledge, skills or training to ensure that the WVPP is implemented and overseen effectively. OSHA envisions that this individual would be responsible for ensuring that the plan is: written, implemented and reviewed; provided to all employees who require training; and followed establishment-wide. The WVPP would need to be promptly updated if there is a change in the designated program administrator.

Under paragraph (c)(3), OSHA would require that covered employers *reevaluate* policies and procedures on a regular basis to identify deficiencies and take corrective action. In the regulatory text provided in this package, a team consisting of management, non-managerial employees, and their employee representatives (if applicable) would review and update the WVPP at least annually. Employers must also conduct subsequent area-specific hazard assessments in response to any workplace violence occurrences in an area not previously identified as high-risk, physical changes in the workplace that could increase the risk, or changes in clientele or services provided that could increase the risk (this is explained in further detail in the explanation for paragraph (d)(4) – *Additional hazard assessments*). The team would also evaluate records and information pertaining to the implementation and effectiveness of the WVPP as part of the review.

Employers would be required to establish and maintain written records for each review and/or update of the WVPP. OSHA anticipates the written review would include effectiveness of training, incidents that have been reported, compliance with the plan, and a determination of whether the written program has adequately addressed the roles, expectations and clear procedures for all job duties. Management would share workplace violence prevention evaluation reports with all workers. Any changes in the program would be discussed at regular meetings of the established committee, with employee representatives or other employee groups (if applicable), and shared with all employees. OSHA has included privacy provisions in the draft regulatory text to ensure that any reports that are generated and audited as part of the WVPP review would protect worker and patient confidentiality either by presenting only aggregate data or by removing personal identifiers if individual data are used.

Paragraph (c)(4) of the draft rule would require employers to allow sufficient time for employees to complete any required WVPP activities (e.g., training, reporting, incident reviews, etc.) at a reasonable time and place. This requirement is intended to ensure employee involvement in all aspects of the program. See paragraphs (f) - Training and (g) -Violent Incident Investigation and Recordkeeping for further discussion.

Paragraph (c)(5) would require employers notify all employees within the entire establishment

(regardless of duties) about the existence and contents of the employer WVPP. The employer must also clearly communicate to all employees how to report workplace violence incidents and who to contact with questions. This notification is to be posted on-site in writing in conspicuous areas accessible to all employees, but OSHA realizes that employers may also wish to utilize other communication methods (newsletters, intranet system postings, etc.) to supplement these physical postings. A copy of the WVPP and the most recent workplace hazard assessment and effective procedures to mitigate hazards must be always made available and accessible to all staff. OSHA welcomes feedback on the draft WVPP requirements.

(d) Workplace Violence Hazard Assessment.

Paragraph (d) of the draft standard requires each employer to conduct a hazard assessment of risk factors throughout the establishment. These employer evaluations are intended to identify environmental and organizational risk factors that may occur throughout a fixed establishment site. This is done by gauging the likelihood of workplace violence incidents and determining the best way to remove or minimize the risk. There are several provisions required to accomplish this assessment.

As stated above in the discussion of the WVPP, a successful hazard assessment needs the commitment of management, involvement of employees, and tailoring to the types of services provided and the volume of patients/clients/residents and their visitors. A successful hazard assessment will identify risk factors that contribute to the likelihood of violence in the workplace. Many risk factors relate to patients, clients, and care delivery settings and include: working directly with people who have a history of violence, people who abuse drugs or alcohol, patients with a condition that causes confusion or disorientation, or distressed relatives; poorly lit corridors, rooms, parking lots, and other areas; lack of a means of emergency communication; and unrestricted movement of patients or clients and their visitors within facilities. The assessment would help inform decisions regarding the types of controls that would best meet the needs of each establishment and take into consideration the types of services provided, the size and layout of the physical buildings and surroundings, and other environmental and organizational characteristics.

Physical injury or threat of physical injury caused by the action of a patient or client, their family, or visitors may not be entirely eliminated for employees who must be physically close to patients/clients/residents, their family, or visitors when administering care. Factors associated with employees' risk of workplace violence include the frequency and duration of close contact, characteristics of the physical environment where the interaction occurs, and organizational characteristics related to the policies, procedures, work-practices, and culture of safety in the organization. These types of characteristics, or risk factors, can be addressed by 1) the actions management takes to improve worker safety; 2) worker participation in safety planning; 3) the availability of appropriate protective equipment; 4) the influence of group norms regarding

acceptable safety practices; and 5) the organization's socialization process for new personnel, all of which promotes a healthy organizational culture of safety.

OSHA's regulatory approach for hazard assessments is to focus on desired, measurable outcomes, rather than relying on many prescriptive regulatory provisions. Each employer could tailor their assessment to the highly variable risk levels of the establishment's patient/client/resident mix, the physical characteristics of the establishment, the volume of patients and clients, and characteristics of the surrounding community.

The provisions for workplace hazard assessment would help assure that employers proactively collect and review existing information, inspect the workplace for threats to employee safety, characterize the nature of the identified risks, and develop a reasonable plan to mitigate identified risk factors in a timely manner. These provisions would help employers institutionalize processes and procedures known to effectively identify hazardous situations between patients, clients, and visitors and employees in the workplace and evaluate risks on a continual basis. The provisions would provide the framework for the hazard assessments. These provisions are important because one of the root causes of workplace injuries, illnesses, and incidents is the failure to identify or recognize threats to employee safety that are present or can be reasonably anticipated.

OSHA would require in paragraph (d)(1) that all covered employers conduct a workplace hazard assessment to facilitate prevention of patient, client, or visitor-initiated violence against employees. The workplace hazard assessment would apply to employers providing healthcare or social assistance services within an employer-operated fixed-establishment site of care. In this context, an establishment means the totality of the space operated by the employer or host employer. This may include a host employer that controls operations within several buildings or even a sprawling campus with multiple buildings, parking lots, or satellite sites. All covered employers who provide healthcare and social assistance services in fixed-establishment sites of care would conduct the workplace violence hazard assessment described here.

Employers would tailor the structure of their hazard assessment to many other factors including the manner in which care is organized and provided (modalities of care); whether the establishment is located in a rural or urban setting; federal, state and local laws; and other business practices. Under the draft regulation, employers would have the flexibility to determine the best approach to accomplish the overall hazard assessment. In addition, each hazard assessment could be tailored to specialized clinical services, the physical characteristics of the establishment, the number of patients and clients in the establishment, and characteristics of the surrounding community of the establishment. For example, smaller facilities with lower volumes of patients or clients might require a minimal level of infrastructure and effort to regulate the flow of people in and around the establishment in order to manage risk appropriately.

Conversely, the high volumes of patients or clients in large facilities may present a higher likelihood for employees to unknowingly be at risk for violent behavior given the amount of client and visitor movement in and around the establishment.

Paragraph (d)(1)(i) would require covered employers to provide an opportunity for employees to report workplace violence incidents, whether or not the incident resulted in an injury, that occurred in the establishment during the previous three years. Paragraph (d) requires employers to record any previously-unreported incidents, and to conduct a review of these reports. It is important for employers to fully engage employees in the hazard assessment process. Although management is responsible for controlling hazards, workers have a critical role to play in helping to identify and assess workplace hazards because of their knowledge and familiarity with the operation of the establishment, process activities, and potential threats.

In particular, workers who provide direct patient care have front-line experience, are very knowledgeable about the risks their patients present, and have familiarity with the operation of the establishment and their job tasks. These workers include, for example, clinicians, nurses, therapists, technologists, technicians, and nursing aides, patient observation aides, environmental services staff, etc. A hazard assessment would ideally be made by a team that includes senior management, risk management staff, supervisors, and both clinical and non-clinical workers. Representation of emergency response teams and/or security staff would also be helpful. Depending on the size and structure of the organization, the team may also include staff representing other operations of the establishment including environmental services, employee assistance, dietary services, security staff, occupational safety and health, risk management, human resources, and others.

Some employees, out of consideration of a patient's mental health status at the time, may not report patient acts of violence against them to their supervisors, and regard patient outbursts as normal coping mechanisms. As has been reported by the GAO and in the literature employees often choose not to report an incident to the employer for various reasons, including: the perception that workplace violence is part of the job; lack of policies, procedures, and staff training; time consuming reporting procedures; lack of support or follow-up; fear that the employee would be blamed; or that patients are not accountable for their violent actions. (Findorff, et. al. 2005, Arnetz, et. al., 2015, Ex. 0006)

Employee perceptions of workplace violence incidents leading to underreporting can cloud the review of past incidents. Patterns of patients' behavior and the effect of environmental and organizational risk factors may not be detected when incidents are not reported. The requirement in paragraph (d)(1)(i) gives the employees an opportunity to report all such incidents without the threat of harm or further retaliation from the patient, family, or visitors. The employee reporting element of paragraph (d)(1)(i) is intended to yield a more robust and effective hazard assessment

when the employer makes clear that reporting of workplace violence incidents is both expected and required.

Paragraph (d)(1)(ii) would require that employers record all previously-unreported workplace violence incidents in the establishment in the previous three years in order to best inform their hazard assessment. OSHA expects that these unrecorded incidents will typically be at the level where they did not meet the criteria for reporting to OSHA (e.g., there were not injuries that required hospitalization or missed work time) in order to provide the most accurate portrayal of workplace violence hazards possible. During an employer's first hazard assessment, OSHA is contemplating that the employer would consider the collection of employees' recollection of incidents, including threats, which occurred before the implementation date of a rule. Although details of an incident are frequently hard to recall precisely as time passes, OSHA expects that capturing information from as many former incidents as possible would be instrumental in identifying risk factors and planning interventions during the first hazard assessment.

Paragraph (d)(1)(iii) would additionally require employers and participants in the review process to examine all workplace violence incidents that occurred within the previous three years. These incidents could have been experienced by an employee or contractor, vendor, and/or licensed independent practitioner with privileges. The employer would evaluate, at a minimum, all data recorded in the violent incident log and incident investigations and data from all other available sources, including surveys of employees; OSHA 300 logs; Workers' Compensation claims; insurance loss information; and other ward-specific incident logs. A review of incidents would focus on characteristics of the employee involved, the patients or clients committing the incidents, and the physical and social settings in which the events occurred.

Under paragraph (d)(1)(iv), employers would also be required to evaluate employee risk for workplace violence based upon the level and types of crime in the employer's served community. For example, emergency departments (EDs), because they typically serve the community 24 hours a day and are generally accessible to the public, may expose employees throughout the establishment to the community at large. Criminal occurrences in the community at large can spill into the ED or other specialty services such as intensive care trauma units (Blando, et. al., 2012; Joint Commission, 2021a) Employees who work in facilities in or near high crime areas could be at risk as they enter and leave the healthcare establishment or while delivering care to patients/clients/residents residing in or near areas with increased levels of crime and/or specific types of crime. An assessment of the level and types of crime in the surrounding community would help determine appropriate and most effective types of controls.

OSHA expects that employers will access such information, free of charge, through the use of publicly accessible web-based resources such as the FBI Criminal Justice Information Services (CJIS) - Uniform Crime Reporting Program Crime Data Explorer resource to obtain data at the

county or city law enforcement agency level, or even more granular and individual community level data available from such resources as CityProtect, SpotCrime, or Lexis-Nexis Community Crime Map.

Paragraph (d)(1)(v) would then require employers to assess all areas of their establishment for the following risk factors:

(A) Employees with direct patient/client/resident care or contact duties working alone or in remote locations, or during night or early morning hours.

(B) Locations within the establishment without emergency communication, such as areas where alarm systems are not installed or operational, or where any obstacles and impediments to accessing alarm systems may exist. The lack of security systems, alarms, or devices can limit staff's ability to seek assistance and limit appropriate response to situations where violent incidents are imminent or have occurred, increasing the likelihood or the severity of an incident.

Obstacles and impediments to accessing alarm systems or locations within the establishment where alarm systems are not installed or operational may present undue risk for workplace violence. All employers must ensure an escape route out of the area for all of its employees. Every escape route will be assessed to determine that the employee can move from the area of violence to a safe area, unimpeded by obstacles. Hallways should have a clear path to a safe area or to the outside of a building. Doorways, whether alarmed or not, should be unblocked and swing free to an open space in the building or to the outside.

(C) Ineffective communication mechanisms or practices regarding patient/client/resident status between shifts and between personnel. The employer would be required to evaluate whether the communication of patient/client/resident information is effectively handled. If ineffective communication mechanisms or practices regarding patient/client/resident status between shifts and between personnel are identified, new or updated policies or protocols will need to be developed and implemented. Information about a patient's or client's propensity for violent behavior can be obtained from care provider notes, notes from the transferring units within or external to the establishment, or emergency medical services staff who may have transported a patient to an emergency department. Inadequate communication between work shifts and between personnel among the various care units, clinics, and departments, may expose employees to undue risk of workplace violence incidents. In addition, inadequate communication about a patient's or client's propensity for violent behavior can increase risk for employees who are unaware of this propensity, and hinder appropriate changes in staffing, procedures, or duties. If employees know patients'/clients' history of aggressive behavior, they may also be better able to recognize warning signs and intervene to avoid a violent incident.

In addition, paragraph (d)(1)(vi) would require employers to assess all high-risk service areas. In

these high-risk service areas, employers must also assess for additional risk factors. The levels of risk associated with these specific risk factors depends on unique environmental and organizational characteristics of each establishment. Host employers would evaluate their facilities and implement interventions with the intent of minimizing frequency and severity of workplace violence incidents associated with high-risk services. These risk factors can be identified during a walk-through inspection by an assessment team, especially if it is a large establishment, or by a single employee in a small establishment. The host employers operating large facilities usually provide many types of services where employees interact with patients and clients. Conversely, it might be appropriate that only one employee who is intimately familiar with the patient mix, building, and services of a small establishment such as a small residential behavioral health group home would be capable of performing a walk-through inspection to identify risk factors for workplace violence.
The additional assessments for high-risk areas include:

(A) Poor illumination or areas with blocked or limited visibility. These areas pose a high-risk factor, limiting employees' ability to detect and avoid potential threats of harm during their course of work. An area having poor illumination or limited visibility impedes the safety of employees performing work in these areas. Repositioning light fixtures, changing to LED bulbs, or installing motion sensors on lights to turn on when there is movement, and use of convex mirrors or video equipment in those areas are all examples of how better visibility can be accomplished.

(B) Employee staffing patterns that are inadequate to reduce workplace violence or to respond to workplace violence incidents. Employee staffing patterns vary by establishment, and depend on the acuity of the patients or clients served. OSHA considers inadequate staffing to be a risk factor in workplace violence because it can both agitate patients/clients/residents as well as prevent prompt response if a workplace violence incident occurs.

(C) Lack of physical barrier protection between employees and patients/visitors in areas such as admission, triage, and nursing stations. It may be necessary to provide physical barrier protection in some areas of an establishment. Patients, clients, and visitors to healthcare and social assistance settings may experience increased stress and agitation that increases the risk of violent behavior. Those employees working in an admissions office or a triage desk may encounter hostile patients/clients/residents. Having a clear partition between the employee and the patient/client/resident will provide a protective barrier, while not impeding the communication process.

(D) Lack of effective escape routes. Employees can be at risk when entering a resident's room, an examination room, or other areas where a patient or client could easily maneuver to limit the opportunity for retreat, to alarm, or otherwise seek help.

To the extent feasible, rooms should have two exits. Doors may be outfitted with panels that can be kicked or popped out by responders in the case of barricaded doors.

(E) Entryways where unauthorized entrance may occur, such as doors designated for staff entrance or emergency exits. Unregulated and unmonitored patient, client, and visitor movement in and around the establishment via entrances/exits, halls, rooms, or stairwells, provides the opportunity for uncontrolled contact between employees and patients or clients, elevating the likelihood of workplace violence incidents. This provision would require that all entryways be assessed to determine if an unauthorized entrance could occur. Any doors that are designated for staff entrance or emergency exits should be assessed to ensure that only those with the authority to enter/exit can gain access and no other individual can enter/exit, possibly using an audible alarm.

(F) The presence of unsecured furnishings or other objects that could be used as weapons. Employers would be required to assess the furnishings provided (e.g., chairs, tables, wall hangings, curtain rods, blinds, clocks, pole-based medical equipment) in high-risk areas to determine if these objects could be weaponized. Any item that is not bolted down or connected together could be swung or thrown toward an employee by an aggravated individual if a situation escalates.

OSHA would also require that the employer establish a system for promptly addressing the findings from the hazard assessment, and a plan to abate the hazards and risk factors in an immediate or timely manner. This plan includes a written schedule of when such actions are to be completed and communication of these actions to employees who may be affected by the identified risk factors. Paragraph (d)(2) would mandate that each employer establish and implement effective procedures to address the findings from the hazard assessments and maintain written records of these plans as they progress over time. OSHA believes that a written record is an essential component of communicating and managing risks within an organization. Written records document that an assessment was made, identify which job tasks or occupations might be affected, and account for the number of people who could be involved.

Employers would be required to maintain these written records that document the risk factors that were identified and addressed, that abatements were well reasoned and appropriate, and that any remaining risk was minimized. OSHA believes that requirements for written documentation help to track the progress of the worksite hazard controls, and is contemplating requiring hazard identification, evaluation, and correction records to be maintained by the employer for three years (as specified in paragraph (d)(1)(2)(x) and (h)(1)(ii)), or for as long as there is an unresolved hazard mitigation project pending or still in progress. A copy of the procedures to address the findings of hazard assessments fulfilling the requirements in this section would also become part of the written WVPP.

To implement these procedures, paragraph (d)(2)(i) would require that written records of the hazard assessment be maintained and include identification of any high-risk service areas.

Paragraph (d)(2)(ii) would require the identification of any specific hazards or risk factors found.

Under paragraph (d)(2)(iii), employers would be required to develop a plan to abate the identified hazards or risk factors in an immediate or timely manner during the interim of more permanent abatement.

Under paragraphs (d)(2)(iv) and (d)(2)(v), employers would also be required to document the date(s) that the assessment was performed, along with the names and titles of the individuals who participated in the evaluation.

Paragraph (d)(2)(vi) would require that the procedures to address the findings of the hazard assessments include the actions planned to address and prioritize the mitigation of the identified hazards or risk factors permanently.

Paragraph (d)(2)(vii) would require employers to communicate the status of planned or completed actions to all employees who may be affected by the identified hazards or risk factors.

Paragraph (d)(2)(viii) would require documentation of dates by which the employer's planned mitigative actions are to be completed.

In paragraph (d)(2)(ix), OSHA has outlined draft requirements for employers to maintain written documentation of completed actions including the method(s) of control decided upon; the areas where controls were implemented; and specific date(s) of completion, including the names and titles of the individuals who authorized and managed implementation of controls.

Paragraph (d)(3) specifies that hazard assessments must take place annually. The annual review would include an assessment of the previous three years of workplace violence incidents. As part of this annual review, employers may need to designate an area to be high-risk based on the occurrence of a WPV incident. Likewise, an employer may determine that an area it previously deemed to be high-risk no longer is high-risk because there have been no incidents in the past three years. For example, if an incident occurred on a pediatric unit that was caused by a distressed or grieving parent three years ago, but no other incidents have been identified since, that unit could be re-classified as non-high-risk, provided that documentation exists to verify no new incidents. Areas OSHA defined as high-risk would still be deemed to be high-risk, even if no incidents occurred in those areas within the previous three years.

Similarly, if changes to the establishment's business model (such as the acuity of patients treated or the types of services provided) reduce the workplace violence hazard in a particular area, those changes could be considered as part of the annual hazard assessment. For example, if an institutional reorganization results in the establishment no longer providing behavioral healthcare

or emergency room care, incidents in those areas would not be considered if the employer documents the lack of continuing need for that designation.

Paragraph (d)(4) requires employers to conduct additional area-specific hazard assessments in three situations. First, employers must conduct an additional area-specific hazard assessment when there has been a workplace violence incident in a service area or activity not previously identified as high-risk, in which case the assessment must be conducted within thirty days (*see* paragraph (g)(3)(ii)). Second, an additional area-specific assessment would be necessary when changes are made to the layout, design, or amenities of the physical workplace, such as installation or relocation of new nursing stations, reception desks, addition or renovation of patient counseling rooms, etc. OSHA believes that additional assessments under these circumstances would reduce the likelihood of a workplace violence incident stemming from the change.

Third, an additional hazard assessment is needed when a change in the clientele or services provided could increase the risk of workplace violence. For example, if there is an increase in the acuity (e.g., increased nursing care, higher-risk social services clients, etc.) of the patient or client population or new high-risk services are provided (e.g., substance abuse treatment center), these changes warrant an additional hazard assessment.

Paragraph (d)(5) of the draft regulatory text addresses employers' hazard assessment responsibilities on a multi-employer worksite. This paragraph requires the host employer to conduct the hazard assessment and other employers to coordinate with the host employer to provide any information requested. OSHA believes that as the controlling employer of the establishment, the host employer is best-suited to take the lead on performing the hazard assessment. Each contractor, vendor and/or licensed independent practitioner with privileges, working at a worksite covered by the standard must coordinate with the host employer to comply with all provisions in paragraph (d).

This coordination would involve providing information on any incidents of workplace violence or communicating any hazardous risk factors that may lead to workplace violence. Host employers would also be required to share any information within their establishment related to the implementation of new or revised policies or procedures to address the findings from the hazard assessments with staffing agencies or other employers in the host employer's worksite. OSHA is particularly interested in engaging with SERs to receive insight and feedback on how multiple employers who share a common work site currently coordinate their safety and health efforts in healthcare and social assistance industry sectors.

Paragraph (d)(6) specifies that paragraphs (d)(1)—(5) do not apply to home healthcare and field-based social assistance service employers or emergency medical services employers that place

employees in these settings. These employers would instead complete the hazard assessment elements in Table E-1: Home Healthcare and Field-Based Social Assistance Services, or Table E-2: Emergency Medical Services. The provisions in paragraph (d) are intended for fixed establishment-based employers with more control over the workplace.

Home healthcare and field-based social assistance services are unique in that they are provided outside of a fixed worksite, and are usually at the site of the patient's or client's residence. The variety of non-institutional environments within private residences, the types of services, and characteristics of communities, provide a unique challenge for employers in this field to provide a safe work environment for employees. Consequently, the requirements for workplace assessments for home healthcare and field-based social assistance services would be mandated in Table E-1: *Home Healthcare and Field-Based Social Assistance Services – Workplace Hazard Assessments and Control Measures.* Those provisions that apply for emergency medical services, which are performed in a variety of locations, can be found in Table E-2*: Emergency Medical Services – Workplace Hazard Assessments and Control Measures.*

(e) Control Measures.

Effective management of workplace violence in healthcare and social assistance requires the development of controls to reduce the risk of workplace violence by means of preventing and reducing the severity of these incidents. Once an employer's hazard assessment is completed, control measures need to be considered and implemented for each identified risk factor. In rulemaking, OSHA considers the *hierarchy of controls* in determining the methods for controlling worker exposures to occupational hazards. Traditionally, the hierarchy of controls has been used to determine exactly how best to implement control solutions that are both feasible and effective. Generally, following this hierarchy of controls leads to the implementation of inherently safer systems to reduce the risk of illness or injury. The main concept behind the hierarchy of controls is that control measures can be grouped into categories of elimination, substitution, engineering, administrative/work practice controls, and finally, personal protective equipment (PPE). The hierarchy of controls is ordered in just that sequence, by most effective to least effective methods of control.

Elimination and substitution, which are generally the most effective control methods for reducing hazards, are concepts that tend to be less broadly applicable to controlling workplace violence in healthcare and social assistance settings. Therefore, OSHA has focused primarily on various engineering and administrative/work practice control strategies, and to a lesser extent, PPE, in this draft standard. The draft regulatory text requires employers to establish and implement workplace violence control measures based on the nature of the hazards to minimize the risk for workplace violence.

OSHA is considering multiple methods of control measures that would apply to all fixed

(establishment-based) worksites. OSHA has also identified multiple control measures for non-fixed worksites and worksites over which an employer may have less direct control (e.g. those of field-based emergency medical services or field-based healthcare or social assistance services).

Engineering Controls

The purpose of implementing an engineering control is ultimately to isolate or contain the workplace hazard from the worker. In healthcare facilities, engineering controls are physical changes to the workplace itself--usually an aspect of the built space or a device that removes or reduces a hazard, or creates a barrier between an employee and the hazard. Engineering control strategies could include, for example:

- Access controls to employee-occupied areas;
- Enclosed workstations with shatter-resistant glass;
- Deep service counters or other means to physically separate patients/clients/residents and their visitors from employees;
- Separate or isolation rooms or treatment areas for patients with a history of violence;
- Locking mechanisms for doors;
- Removing access to or securing items that could be used as weapons;
- Furniture affixed to the floor;
- Closed-circuit video monitoring and recording;
- Metal detectors at entrance points (installed or handheld);
- Other means of assuring visibility such as mirrors and improved illumination;
- Personal alarm devices; or
- Other engineering controls.

Engineering controls are only reliable so long as the controls are designed, used, and maintained properly. Without regular check and routine maintenance, the effectiveness of engineering controls become diminished. For example, video surveillance systems can be an effective tool for workplace violence prevention but if the equipment is not maintained, it can degrade with time, which may go unnoticed until it is no longer useful. Additionally, physical barriers engineered to protect workers are only effective if the physical integrity is assessed and maintained.

Where it is appropriate, several engineering control measures together can serve to prevent or minimize employee workplace violence incidents. For example, convex mirrors can be positioned above walkway intersections in conjunction with increased illumination to reduce the risk of entering a blind spot. Engineering controls for workplace violence prevention are also tangible solutions that can prevent a person who could be attempting to harm others or introduce a dangerous object from entering a work site.

Administrative and Work-Practice Controls

Administrative and work-practice controls are also important ways for employers to protect employees from workplace violence hazards. Administrative and work-practice controls are changes to the way staff perform jobs or tasks, both to reduce the likelihood of violent incidents and to better protect staff, patients, and visitors should a violent incident occur. Examples of work practice controls include maintaining sufficient staff for the hazard, as well as providing training on de-escalation techniques and how to respond to workplace violence. As with engineering controls, the practices chosen to abate workplace violence by means of administrative or work practice controls should be appropriate to the type of site and responsive to risk factors identified during the hazard assessment described in paragraph (d).

For example, establishing a system of communication—such as chart tags, log books or verbal census reports—can identify patients and clients with a history of violence and identify triggers and the best responses and means of de-escalation. OSHA is considering provisions that would require employers to ensure that their workers know and follow procedures for recording and communicating updates to patients' and clients' behaviors.

Administrative and work practice controls should evolve along with changes in the workplace. Once administrative and work practice controls are implemented, these controls would be evaluated at least annually, in conjunction with the annual hazard assessment described in paragraph (d), to ensure effectiveness. These annual reviews will allow for regular upgrades or modifications to administrative/work practice controls, if necessary.

Some additional examples of administrative controls include: developing standard operating procedures for the control of and response to a workplace violence incident and determining the behavioral history of new or transferred patients or clients to learn about any past violent or assaultive behaviors. Employers should also have procedures for summoning help during a workplace violence incident and procedures for staff designated to respond to a workplace violence incident.

Personal Protective Equipment (PPE)

Finally, employers may provide PPE where appropriate, and where engineering and/or administrative work practice controls alone are not fully sufficient to abate a given hazard. In the case of WPV, examples of appropriate PPE could include eye protection, and splash guards. In extreme cases within some behavioral health or psychiatric settings this could include the use of padded convex shields or scratch/bite resistant Kevlar sleeves, etc. These types of PPE controls are occasionally needed in specialized settings where the potential for violence is extremely high.

<u>Controls Contemplated for All Covered Workplaces</u>

OSHA solicits feedback on the controls identified in the draft regulatory text. As noted in paragraph (e)(6), the provisions in paragraph (e) would not apply to home healthcare and field-based social assistance service employers or emergency medical services employers. These employers would instead implement the control measures in Table E-1: Home Healthcare and Field-Based Social Assistance Services, or Table E-2: Emergency Medical Services. This is because the provisions in paragraph (e) are intended for establishment-based employers that maintain more primary control over their operations within their facilities, and employers in home healthcare and field-based social assistance service, or emergency medical services may operate with less direct control of the working environment. For all other settings, OSHA is considering a series of general engineering, administrative, and work-practice control measure requirements, as well as requirements for PPE, that would be applicable to all covered employers. Paragraph (e)(1) specifies that all covered employers would be required to implement certain control measures, including:

- Effective alarm systems;
- Workplace Violence Incident response procedures; and
- Policies for communicating patient/client/resident specific risk factors.

Effective Alarm System

Paragraph (e)(1)(i) requires employers to install, implement, and maintain an effective alarm system for use by employees with direct patient care/direct patient contact duties. Under the draft regulatory text, "alarm" means a mechanical or electronic device by which employees can summon assistance to respond to an actual or potential workplace violence emergency.

Employees with direct patient care/direct patient contact duties need to be able to signal for help whenever and wherever they need it. Alarms would be located in unobstructed locations that are easily accessible to employees. Acceptable alarms include stationary systems like wall-or desk-mounted panic alarm buttons. Some alarm systems provide a silent call signal, while others provide an audible call signal.

OSHA anticipates that most health care facilities already have some form of emergency communication system, such as a wall-mounted alarm or a building-wide public address (PA) system. Many establishments have implemented mass notification systems or have taken advantage of personal safety alarm devices, or smartphone, tablet, or computer-based applications to accelerate emergency responses when a workplace violence incident occurs. OSHA recognizes that many types of alarm systems can be effective and systems may vary depending on setting. For example, a small unit without regular workplace incidents may determine a wall-mounted alarm button is effective, while a setting with more frequent workplace violence incidents may provide employees with personal emergency devices such as panic buttons.

Workplace Violence Incident Response Procedures

The objective when implementing an alarm system is for appropriately trained persons to respond immediately to an employee's call for assistance. Paragraph (e)(1)(ii) would require employers to establish and implement effective workplace violence incident response procedures. Appropriately trained employees must receive the signal for help in order to be able to provide a prompt response.

OSHA expects that any effective workplace violence incident response procedures would include standard operating procedures for a variety of incident response scenarios that might commonly occur at any fixed establishment. For example, paragraph (e)(1)(ii)(A) would require employers to establish and implement standard operating procedures for employees with direct patient care/client care or direct patient/client/resident contact to summon help during a workplace violence incident.

Paragraph (e)(1)(ii)(B) would require employers to adopt standard operating procedures for receiving patients/clients/residents who are actively exhibiting violent behavior, including those escorted by law enforcement officers. These could be individuals with mental health issues who require assistance because they may harm themselves or others. For example, this may be the case when an establishment is receiving individuals who are under the influence of substances, may have been involved in a violent altercation prior to arrival at the establishment, or are from a nearby correctional facility and may have histories of violence. These situations require that, where applicable, safety measures be taken to protect the health and safety of workers while still accounting for the needs of the patient/client/resident. For example, patients/clients/residents being escorted by law enforcement may need to be treated and/or tested in separate areas. Paragraph (e)(1)(ii)(C) would require employers to adopt standard operating procedures for staff designated to respond to workplace violence incidents. Many large healthcare settings may already have emergency response teams with designated members to respond to a variety of situations. At a minimum, workplaces would need to ensure that there is staff available to respond to a workplace violence incident. Some employers may determine it is appropriate to maintain a workplace violence incident response team.

Employees designated to respond to workplace violence incidents will receive advanced levels of training, and response team members may not have other assignments that would prevent them from responding immediately to an alarm to assist other staff. Team members may include clinical patient care/contact staff, a house manager or charge nurse, and/or security. Standard operating procedures would include how to ensure a prompt and coordinated response, as well as any other requirements, such as specialized training or evaluation.

Paragraph (e)(1)(ii)(D) would require that, if an employer uses restraint methods on patients, it

develops standard operating procedures for use of restraints in a manner appropriate to protect employees, particularly for high-risk services. It is the employer's responsibility to ensure that to the extent it relies on restraints for incident response, any restraints used are effective and can be implemented in a way that minimizes risk to employees. Employers who use restraints must develop policies and procedures about when and how to use restraints or isolation, and this information must be provided to employees providing direct patient or client care or others responding to an employee's call for emergency help.

OSHA understands that there are a number of existing federal, state, and local laws on restraint methods designed to protect patients, and OSHA does not intend this standard to interfere with any of those laws. OSHA also understands that the use of restraints are contraindicated in many healthcare and social service settings. OSHA is also aware of research indicating that the use of restraints can be significantly counterproductive to the effective treatment of certain patients. (NABH, 2021) As such, this draft standard does not require the use of restraints. However, OSHA understands that as part of the incident response, isolation or chemical/physical restraints may be an appropriate means to stop or minimize the severity of outcomes due to a patient or client exhibiting violent or disruptive behavior. Whereas OSHA does not intend that these techniques be required to be used by employers, these measures may be utilized in some settings.

Paragraph (e)(1)(ii)(E) would require employers to adopt standard operating procedures to respond to mass casualty threats, such as active shooters. An increasing number of healthcare facilities have begun to incorporate mass casualty scenario planning into their emergency response and workplace violence prevention programs. Active shooter response could include:

- When and how to involve local law enforcement;
- Development of a communication plan;
- Establishment lockdown and evacuation protocols;
- Training and drilling requirements; and
- Planning for post-event activities (e.g., evaluations, de-briefs, counseling).

Incidents of workplace violence may rise to a level that necessitates law enforcement involvement. For that reason, OSHA has included a provision in paragraph (e)(1)(ii)(F) that would require employers to adopt standard operating procedures for obtaining assistance from the appropriate law enforcement agency during all work shifts. These procedures may include establishing a central emergency coordination system (e.g., security desk, charge nurse's station, etc.) for obtaining assistance from law enforcement agencies. The procedures may also identify who the appropriate law enforcement contacts would be and detail and how information is to be reported to external law enforcement agencies.

Communication of Patient/Client/Resident-Specific Risk Factors

Paragraph (e)(1)(iii) requires policies and procedures to communicate patient/client/resident-specific risk factors. This would include instructions for handing off care of patients or clients between employees during shift changes, transferring patients or clients between service units, and other transport. It is especially important to communicate to all relevant employees pertinent information about patients or clients with a history of violent behavior. Employers must also identify and communicate any event triggers for patients/clients/residents, identify the type of violence (including severity, pattern, and intended purpose), and use this information to develop plans to prevent future violence. Covered employers must develop their own system (e.g., chart tags, log books, patient/client/resident handoff tool, census reports) to communicate patient/client/resident-specific risk factors to all employees who may encounter the patient or client.

In many covered settings, it may already be a common practice to engage in patient-management huddles, which could include a discussion of workplace violence and patient or client specific risk factors. OSHA believes it is important to standardize a protocol to ensure that all of the pertinent information is captured and communicated to all appropriate employees, which can help employees take adequate steps to anticipate or prevent workplace violence incidents before they occur. Practical checklists can be developed to collect general information on patient or clients that have exhibited, or are a potential risk for, violent or disruptive behavior. Such information may already regularly be obtained at admissions or through an initial consultation in the case of social assistance or home healthcare.

Paragraph (e)(1)(iii)(A) would require covered employers to establish and implement policies and procedures for employees to document and communicate a patient or client's prior history of violence, to the extent that such history is known to the employer or can be determined by records within the employer's possession. OSHA believes that there is some variability with respect to the amount and level of detail that employers have access to in a patient or client's electronic health records. Additionally, some but not all employers, particularly those in emergency departments within larger urban hospitals, may have access to law enforcement databases. Only history that is known to the employer needs to be communicated; OSHA does not expect employers to conduct an in-depth background check of anyone who presents for treatment.

Paragraph (e)(1)(iii)(B) would require covered employers to establish and implement policies and procedures for employees to document and communicate any conditions that may cause the patient/client/resident to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively. For example, diagnoses of mental or behavioral illness would be informative, as would any recent changes in medication or treatment that had been previously effective in controlling aggressive behavior (e.g., the employer knows that the

patient recently stopped taking medication that had been used to control anger and aggression). Information about patient alcohol or substance abuse or withdrawal symptoms would also be helpful to employees who will likely have contact.

Paragraph (e)(1)(iii)(C) would require covered employers to establish and implement policies and procedures for employees to document and communicate any *recent* disruptive or threatening behavior displayed by a patient/client/resident. This refers to the maintenance and communication of these behaviors during the time the patient or client has spent with the care provider.

Paragraph (e)(1)(iii)(D) would require covered employers to establish and implement policies and procedures for effective communication via flagging and the use of visible cues of a patient or client's history or potential for violence on patient charts or client case history for all relevant staff. OSHA believes that many healthcare and social assistance employers use computerized systems (e.g., Epic) that allow for service providers to enter patient/client/resident data associated with propensity for violent behaviors that will pop up as an electronic flag in the form of a banner, symbol, or abbreviation on the screens of subsequent healthcare providers each time that patient's file is opened. Additionally, simple stickers of certain colors, shapes, or icons may be placed on patient-assignment boards, patient room doors, above a patient's bed, or on their mobility aids to serve as effective safety cues – particularly for members of the care team who may not have access to patient medical records (e.g., housekeeping, maintenance, dietary staff, etc.)

In many covered workplaces, the practice of flagging patient charts or case histories with a patient's history or potential for violence may already be a standardized practice. However, it is critical that everyone who interacts with a potentially aggressive or violent patient is aware of that potential. Unlike emergency response protocols that notify workers of violent situations actively in progress, the practice of flagging patient records draws attention to the *potential* for violence. It involves exchanges of information that consist of visual and / or electronic cues that are easily recognizable. By taking this kind of proactive approach to managing violent or aggressive behaviors, employers can reduce the risk of harm to workers. OSHA seeks feedback on the types of visual cues currently used in the healthcare and social assistance sectors and whether SERs have found such cues to be helpful in reducing the risk of workplace violence.

Paragraph (e)(1)(iii)(E) would require employers providing direct care to establish and implement policies and procedures to document and communicate a patient or client's treatment and medications, including the type and dosage, as is known to the establishment and employees .

Under paragraph (e)(1)(iv), employers would be required to establish and implement policies and procedures for effective communication of a patient/client/resident's history or potential for

violence to all subsequent external healthcare employers that a patient may be referred to. Much in the way that paragraph (e)(1)(iii) would establish requirements for employers to communicate information about a patient or client's prior history of violent, disruptive, or threatening incidents. OSHA is considering requiring such information to also be provided to that patient/client/resident's subsequent healthcare providers. One potential approach would be to implement a flagging alert program to communicate violence-related risks to healthcare teams. As described earlier, OSHA believes that many healthcare and social assistance employers use computerized systems that allow for service providers to enter patient/client/resident data associated with propensity for violent behaviors that will pop up as an electronic flag for subsequent providers. OSHA believes this type of communication will help subsequent healthcare providers better prepare and anticipate the workplace violence risk and take proactive steps to address it.

Again, only a patient/client/resident's known history is required to be communicated and employers are not expected to conduct an in-depth background check of anyone who presents for treatment. Furthermore, the communication of sensitive information must, of course, follow federal, state, and local laws.

Controls in High-Risk Service Areas of Covered Fixed Facilities

As noted above, paragraph (b) defines high-risk service area as a setting "where there is an elevated risk of workplace violence incidents." Such services and settings would include "emergency rooms/emergency admissions/ triage areas, psychiatric care, behavioral health care, substance abuse treatment, home healthcare, social assistance, emergency medical services, and other areas deemed to be of high-risk for violence by the employer." In general, any service area wherein a workplace violence incident has been recorded in the previous three years is to be considered high-risk unless there is a written determination of why this designation is not appropriate. An isolated incident and one that is not likely to happen again may not be grounds to designate that unit a high-risk area, so an employer would need to document that such a designation is inappropriate in this case. For example, an isolated domestic dispute in a maternity ward that customarily does not see such instances may not alone warrant designation as a high-risk service area. These high-risk areas would require additional engineering controls and work-practice controls be put into place to ensure the safety of employees.

OSHA recognizes that each healthcare and social service establishment is unique and thus workplace hazard assessments will identify different hazards. OSHA expects that controls selected would be site-specific and appropriate to the specific setting. For example, closed circuit videos and shatterproof glass may be appropriate for one particular hospital or other setting with a history of workplace violence incidents, but perhaps less-so for some other community care establishment that has never experienced such an episode. Due to the complexity of workplace violence in healthcare and social assistance, OSHA expects that employers would adjust and

tailor all control measures for each establishment or service area based on the specific risk factors that are identified during hazard assessments. (e.g., size of the building, patient case-mix, type of services provided, prevalence/type of crime in the surrounding community).

Engineering Controls in High-Risk Service Areas

In paragraph (e)(2) OSHA outlines draft requirements for employers to implement additional engineering control measures to prevent or reduce the risk of workplace violence in high-risk service areas. Paragraph (e)(2)(i) would require that in high-risk areas, employers must ensure that employees have a clear line of sight in public areas of the establishment, including waiting rooms and hallways, so that employees can observe all activities in areas where members of the public are moving through care or service areas from their work stations without impediment by room design, furniture, and/or other objects. This includes ensuring that no sight barriers exist, sufficient illumination exists, surveillance systems or other sight aids are installed such as convex mirrors in ceiling corners, and other effective means. The purpose of this requirement is to ensure employees are able to observe what is happening around them.

Paragraph (e)(2)(ii) would require that employers ensure that employees have unobstructed access to alarms and exit doors as a means to escape violent incidents in high-risk areas. Employees must have unobstructed access to exit doors and alarms in in all high-risk areas in order ensure the ability to escape violent incidents. Additional modifications to the physical layout of high-risk service areas be could be implemented to accommodate access to exit doors where appropriate.

For example, if a hazard assessment indicates that nurses are at risk when working with a bedside intravenous therapy apparatus because they must position themselves with the bed blocking the alarm button and the door, then the resulting control could then be to modify the physical layout of a patient's room. The bed and medical equipment could be moved in order to ensure that alarm systems are not blocked. Administrative controls that may also mitigate this hazard could be to train employees to interact with patients from the side of the bed next to the door and alarm to the extent that it is possible.

Paragraph (e)(2)(iii) would require employers to remove, fasten, or secure furnishings and other objects that may be used as improvised weapons in high-risk areas where direct patient/client/resident contact/care activities are performed. OSHA is aware of many instances where objects were used as weapons to attack healthcare and social assistance workers.

Paragraph (e)(2)(iv) would require that employers install protective barriers between employees and patients or visitors in areas such as admission, triage, and nursing stations in high-risk areas. OSHA is aware of numerous incidents where patients were able to access the nurses' station and attack employees and believes that this is an important and feasible control to prevent such

attacks. Enclosed nursing stations, physical barriers such as deep service counters, or electronic access controls and locks would be appropriate and the employer's assessment could indicate which is most appropriate for the facility.

Paragraph (e)(2)(v) provides that an employer need not implement one of these engineering controls to address the hazard in a particular area if the employer has demonstrated in writing as part of its hazard assessment that the control is not appropriate or feasible for that area.

Work-Practice Controls in High-Risk Service Areas

Paragraph (e)(3) would require employers to implement additional work-practice controls in high-risk service areas. Paragraph (e)(3)(i) would require employers to install, implement, and maintain the use of personal panic alarms or other effective means of automated personal emergency communication for employees with direct patient care/direct patient contact duties in high-risk service areas. In high-risk areas, employees would be provided with personal safety communication devices. These devices can be worn and be used to send an alarm signal in the event of a workplace violence incident or when an employee needs assistance in an emergency. These devices include technologies that can send "safe check-in" messages as well as panic alarms. Some devices provide two–way communication ability. OSHA envisions that training on use of these devices (including training on the limitations of these devices) would be a component of this work-practice control.

Paragraph (e)(3)(ii) would require employers to create a security policy to address the movement of authorized and unauthorized persons and weapons into and throughout the establishment. This may involve developing policies on the use of electronic keycards or access codes used to regulate access to certain areas or the use of metal detectors to prevent weapons from being brought into the building and training employees on using metal detectors and removing weapons.

Paragraph (e)(3)(iii) would require employers to maintain staff designated to immediately respond to workplace violence incidents in high-risk service areas. OSHA is aware of numerous workplace violence incidents that occurred because there were not staff available to respond to the incident. OSHA believes that having staff designated to respond to workplace violence incidents in high-risk areas will reduce both the frequency and the severity of such incidents. Under paragraph (e)(1)(ii)(C), employers must develop establishment-wide standard operating procedures for the staff designated to respond to workplace violence incidents; paragraph (e)(3)(iii) requires maintaining sufficient staff that are designated to respond to workplace violence incidents in high-risk service areas.

Paragraph (e)(3)(iv) would require employers to ensure that staffing patterns are sufficient to address the workplace violence hazard. OSHA would require that staffing patterns account for

changes, including: intensity of patients' or clients' needs; the number of admissions, discharges and transfers during a shift; level of experience of nursing staff; layout of the unit; and availability of resources (ancillary staff, technology, etc.). OSHA envisions that the employer would maintain staff at levels appropriate to ensure that patient acuity needs are met, that there are enough staff for all one-to-one orders, for the buddy system to be used for certain patients, etc.

Additionally, paragraph (e)(3)(v) provides that an employer would not need to implement one of these work practice controls to address a hazard if it demonstrates in writing that the control is not appropriate or feasible for that area**.**

Personal Protective Equipment (PPE)

Paragraph (e)(4) contains a draft requirement that the employer must provide appropriate PPE including bite-resistant sleeves, protective facewear, etc. Appropriate PPE should be selected based primarily on the hazards identified during the assessment. In extreme cases within some behavioral health or psychiatric settings this could include the use of padded convex shields. Such PPE controls are occasionally needed in specialized settings where the potential for violence is extremely high. Other examples of PPE would be the use of gowns, gloves and face masks and shields to protect employees from saliva or other body fluid exposure that can occur when a patient is physically violent. The employer would be required to provide all such PPE at no cost to the employee (see paragraph (e)(4) and § 1910.132(h)(1)).

Multi-Employer Worksites

Paragraph (e)(5) provides that it is the responsibility of the host employer to establish and implement all workplace violence control measures. OSHA believes that the host employer maintains the highest level of control over the work environment and seeks feedback from SERs on whether this is appropriate.

Tables E-1 and E-2: Workplace Assessment and Control Measures for Home Healthcare and Field-Based Social Assistance and Emergency Medical Services

OSHA understands that employers who provide services within patients' and clients' private residences, or in other field-based settings, as with home healthcare, home or field-based social assistance, and emergency medical services may have very little control over their employees' working environments.

OSHA believes that patients and clients receiving home healthcare are commonly asked to provide a safe environment for the employee as a formal condition of receiving healthcare, and perhaps to a lesser-degree, social assistance services in the home or other site of care. Patients and clients (and their families or other legally-designated decision-makers) are usually required

to formally agree to these conditions prior to receiving care. OSHA also believes that employers and employees in home healthcare already assess the residence for obvious risks before providing services but may not be in a position to make a thorough assessment to the same degree as those host employers who assess fixed healthcare facilities.

Social service workers employed by various government or private employers also visit clients at their homes, but also may have clients who reside within covered institutional settings, such as residential care facilities or residential behavioral health facilities. Due to the nature of social services, these employers may not always have the same formal conditions of providing services set out with clients as may be the case with home healthcare, and clients may not always necessarily be expecting or welcoming the visit.

Emergency medical service employees' workplaces are highly variable and quite unpredictable with respect to environmental and organizational risks while providing medical services in the community at large. These services are often performed in private residences or public settings where most engineering controls are not possible or appropriate. These employees frequently face emergency situations and provide direct patient care in unfamiliar and highly variable settings. EMS employees providing this care often have no background information regarding persons needing their help. These employees make assessments and decisions quickly based on the immediate circumstances.

In the draft regulatory text, OSHA has provided Table E-1 titled "Home Healthcare and Field - Based Social Assistance Services – Workplace Assessment and Control Measures" ("Table E-1"). This table provides draft assessment and control requirements for employers within the home healthcare and field-based social assistance sectors. OSHA understands that home healthcare and field-based social assistance services are relatively unique in that these services are provided outside of an establishment and instead occur within a private residence where the physical environment is largely outside of the control of the employer. As such, hazard assessments and certain engineering controls may not always be feasible. Paragraphs (d)(1)—(5) and (e)(1)—(5) therefore would not apply in these workplaces.

OSHA believes that many employers in home healthcare, particularly those that receive CMS funding, already conduct an initial assessment of the residence where the care would be rendered consistent with the requirements of CMS OASIS Start of Care Assessments and other OASIS-based assessments triggered by events during the course of care. While this assessment may not be conducted in the same manner as within institutional settings, OSHA believes that such assessments are often routinely conducted as part of the service agreement between the healthcare provider and the client or patient. OSHA believes that the requirements in this draft regulatory text could be incorporated into that process. In each row (labeled (i) through (viii)) of Table E-1 there is both an assessment and control component, as indicated in the two columns

"Assessment" and "Control Methods" of each row. The assessment would be performed annually.

Table E-1 row (i) would require employers to review all workplace violence incidents within the previous three years. Row (i) would also require employers to provide an opportunity for employees to report previously unreported incidents and threats of physical harm, regardless of whether an employee sustained an injury. Row (i) would also require employers to conduct an evaluation of any work practice controls or personal protective equipment that may be implemented to minimize workplace violence hazards.

Once the incident record review is conducted, employers would implement control measures tailored to address the specific risks that have been identified. These measures include:

- Standard operating procedures for incident response;
- Standard operating procedures for obtaining assistance from the appropriate law enforcement agency;
- Policies and procedures for employees to document and communicate patient or client-specific risk factors to other employees, such as during handoffs between shifts; and
- Provision of PPE as appropriate.

Another risk factor to be assessed and controlled is how employees are able to communicate while working alone. Table E-1 row (ii) would require that as part of the assessment, the employer assess the adequacy of two-way personal emergency communications devices that can be used by employees to summon aid when working alone with patients/clients/residents. Following this assessment, row (ii) would require the employer to provide all employees with working personal emergency communications devices (e.g., cell phones equipped with emergency applications, two-way radios, wearable safety communication devices, etc.) that can be used by employees to summon aid. There are a number of devices and systems that can be implemented for communication with employees providing care in a residence. Cell phone apps and two-way radios are examples of some communication devices that can be used to summon aid. Mobile safety devices that accompany employees into the field can have communication software, and can be GPS tracked and outfitted with additional security applications. Employers who provide services across large service areas would need to assess which types of communication devices would ensure adequate coverage for its employees. OSHA is interested to hear from SERs about their experiences with or any limitations with use of such applications.

Table E-1 row (iii) would require an employer to assess the level and types of crime in the community where services are being provided. Following this assessment, row (iii) would require the employer to communicate this information related to the potential for violence in the surrounding community to each employee prior to the employee's first visit. As mentioned earlier, OSHA believes that employers may readily access such information, free of charge,

through the use of resources such as the FBI Criminal Justice Information Services (CJIS) - Uniform Crime Reporting Program Crime Data Explorer resource to obtain data at the county or city law enforcement agency level, or even more granular and individual community level data available from such resources as CityProtect, SpotCrime, or Lexis-Nexis Community Crime Map.

Table E-1 row (iv) would require the employer to assess the efficacy of its procedures for collecting information concerning patients'/clients' history of violence and the history of violence of anyone else in the household, and the employer's procedures to provide that information to employees prior to the first visit. OSHA envisions that employers would establish standard operating procedures for obtaining and communicating to employees any information about a patient/client/resident's history of violence, or the violent history of anyone in the household prior to the employee's first visit. OSHA is aware of a number of workplace violence incidents involving home healthcare or social assistance services where employees were not apprised of the propensity for violence or the criminal history of patients/clients/residents or other members of the household wherein services were provided and were attacked.

As part of the assessment, OSHA expects that the employer would gather relevant information regarding violence from any available patient/client/resident medical records or additional sources of information in the employer's possession. The employer would be required to document this information in the patient/client/resident's chart and update the employee if there is any change in status.
It is important for employers to establish a clear, written policy about providing services in the presence of uncooperative, disruptive, and/or aggressive individuals. Table E-1 row (v) would require employers to assess whether a clear written safety policy exists to indicate the parameters for an employee to provide services in the presence of potentially violent patients/clients/residents or others. Employers would be required to evaluate whether the policy indicates parameters for when to continue the care visit, summon immediate assistance, or discontinue the visit. In response to this assessment, Table E-1 row (v) would require that in response to this assessment, the employer establish clear, written policies for what employees should do if they feel unsafe, e.g., due to aggressive patients/clients/residents or others in the household. Policies must include when an employee should call for assistance or terminate the visit.

Table E-1 row (vi) of OSHA's draft regulatory text contains provisions for the employer to maintain and evaluate written records of the review of workplace violence incidents included in the assessment. Table E-1 row (vi) would also require the employer to create and maintain written records of workplace violence control measures implemented. Written documentation of the controls implemented would include:

(a) The methods of control decided upon;
(b) Area(s) where controls were implemented;
(c) Date(s) by which the controls will be implemented;
(d) Date(s) that the controls were implemented; and
(e) The names and titles of the individuals who authorized implementation of controls.

Table E-1 row (vii) provides that each covered employer would be required to review all incidents of workplace violence annually. Additionally, Table E-1 row (vii) contains a requirement that based on the review of incidents, covered employers must establish and implement additional workplace violence control measures to correct workplace violence hazards.

Finally, in Table E-1 row (viii), OSHA indicates that an employer would not be required to implement one of these workplace violence control measures to address the hazard in a particular area where the employer has demonstrated in writing as part of its review of workplace violence incidents that it is not appropriate or feasible.

OSHA clarifies here that under Table E-1, home healthcare and field-based social assistance services employers would not be required to perform reassessments after each workplace violence incident, as would be required for fixed establishment-based employers covered in paragraph (d). Instead, employers in home healthcare and field-based social assistance would need only to fulfill the requirements in paragraph (g) – Violent Incident Investigations and Recordkeeping with regard to documentation of significant contributing factors, recommendations, and corrective measures taken for each investigation -- which in turn would inform these employers' annual review of incidents required under Table E-1 row (i).

Worksite Assessment and Control Measures for Emergency Medical Services

The draft regulatory text also includes Table E-2 "Emergency Medical Services –Workplace Assessment and Control Measures". EMS employees face many types of hazards, including workplace violence. This table provides the draft assessment and control methods for employers within emergency medical services. Emergency medical services are also somewhat unique in this context, given that that they are provided in a highly dynamic work environment and employees may be working at many different sites throughout the shift. These services range from simple transportation of patients to and from medical care facilities to complex rescue and life support procedures.

EMS employees may not have much time to manipulate/stabilize the environment/situation or assess the patient or others present at the site of the emergency to mitigate the risk of workplace violence. Furthermore, time is of the essence for many patients/clients/residents of emergency medical services care. OSHA believes that employers providing emergency medical services already conduct a brief initial assessment to identify the potential for workplace violence during

each emergency response incident. Therefore, OSHA did not include a requirement for employers to perform a site-specific hazard assessment and to implement specific controls for employees at each site. In each row (labeled (i) through (v)) of Table E-2 "Emergency Medical Services – Workplace Assessment and Control Measures" there is both an assessment and control component, as indicated in the two columns "Assessment" and "Control Methods" of each row. The assessment would be performed annually.

The principal differences between Table E-2 for Emergency Medical Services, and Table E-1 for Home Healthcare and Field-Based Social Assistance is that OSHA has not included requirements in Table E-2 for employers in Emergency Medical Services to establish and implement procedures for obtaining and communicating to employees any information concerning a history of violence by the patient/client/resident or anyone else in the household prior to an employee's first visit. OSHA does not believe that such provisions would be feasible for emergency medical services employers to implement, but would be interested to hear from SERs about their views on this exclusion in the draft regulatory text.

OSHA has also not included a requirement for employers to establish clear, written policies for what employees should do if they feel unsafe, e.g., due to aggressive patients/clients/residents or others in the household. Policies must include when an employee should call for assistance or terminate the visit. OSHA believes that many EMS providers already maintain a very close relationship with law enforcement agencies and frequently share separate duties at the same site. OSHA believes that when EMS providers feel unsafe, it is already customary for these workers to wait for police assistance to secure the scene prior to administering care. However, OSHA would also be interested to hear from SERs about their views on this exclusion in the draft regulatory text.

OSHA clarifies here that in Table E-2, emergency medical services employers would not be required to perform reassessments after each workplace violence incident, as would be required for facility-based employers covered in paragraph (d). Instead, emergency medical services would need only to fulfill the requirements in Paragraph (g) – Violent Incident Investigations and Recordkeeping with regard to documentation of significant contributing factors, recommendations, and corrective measures taken for each investigation -- which in turn would inform these employers' annual review of incidents under Table E-2 row (i).

(f) Training

Education and training are key elements of a workplace violence prevention program and help to ensure that all staff members are aware of potential hazards and how to protect themselves and their coworkers through established policies and procedures. Training raises the overall safety and health knowledge across the workforce and provide employees with the tools necessary to identify workplace safety and security hazards. Training also helps to address potential problems

before they arise and can ultimately reduce the likelihood of workers being assaulted. OSHA solicits feedback on the following regulatory text regarding draft training requirements.

Under paragraph (f)(1), each employer would be required to institute a training program for all employees who have direct patient/client/resident contact, provide direct patient/client/resident care, or are responsible for workplace violence incident response duties, and their supervisory staff. Supervisors and managers would receive at least the same level of training as the staff they supervise. Supervisors and managers would be trained to recognize high-risk situations so they can ensure that workers are not placed in assignments that compromise their safety.

Under paragraph (f)(1)(i), OSHA would require that this training be provided initially (e.g., by the effective date of this standard), prior to the time of assignment (e.g., a new-hire), or when employees are newly-assigned to perform duties for which their previous training did not meet all requirement for the newly-assigned duties. If an employee had received workplace violence prevention training from the employer in the 12 months preceding the effective date of this standard, the employer would need only to provide additional training to the extent that the previous training did not meet the requirements of this standard.

For example, employers in California or Nevada—states that implemented workplace violence prevention regulations in 2017 and 2019, respectively—are likely to already have many employees already in compliance with substantial portions of the training described in this framework. Many other healthcare providers nationwide already maintain workplace violence prevention training programs as well.

Under paragraph (f)(1)(ii) and (iii), employers would need to provide annual training and supplemental training to address specific deficiencies when there are changes to any procedures or controls designed to address workplace violence. This supplemental training may be limited to addressing only these changes.

Supplemental training would also be required when inadequacies in an employee's knowledge or work practices indicate that the employee has not retained the requisite understanding or skills. Supplemental training is also required when any other situation arises in which retraining is necessary to ensure employee protection from workplace violence.

Paragraph (f)(2) provides that the workplace violence prevention training would be required to be overseen or conducted by a person knowledgeable in the program's subject matter as it relates to the workplace. For example, if training is provided from an outside vendor unfamiliar with the specific worksite, these instructors would need to be knowledgeable about the WVPP and how the program would be implemented in the workplace. An internal representative with such knowledge may also need to be in attendance at the sessions.

The training must consist of material appropriate in content and vocabulary to the educational level, literacy, and language of the employees trained. Many healthcare and social assistance employers have employees who speak and understand variety of primary languages other than English and have a wide range of educational backgrounds. As such, any training provided by the employer would be required to be presented with content and language consistent with the educational level, literacy, and language of employees. The training would need to be provided at no cost to employees, meaning that employees would need to receive paid time for the training and the employer would be responsible for all other training costs. The training would also need to beat a reasonable time and place such that employee attendance would not be difficult.

Paragraph (f)(2) also requires that the training provide an opportunity for interactive questions and answers with a person knowledgeable in the program's subject matter as it relates to the workplace. As discussed above, if training is provided from an outside vendor unfamiliar with the specific worksite, these instructors would need to be knowledgeable about how the program would be implemented in the workplace, and an internal representative with such knowledge may also need to be in attendance at the sessions.

OSHA envisions four different training levels, depending on the employees' job duties, risk of exposure, and need to know certain information. The four training levels are as follows:

- Level 1 (Paragraph (f)(3)): The first tier of training would be for employees with direct patient/client/resident contact duties and their supervisors. These would be those employees who perform support work that requires them to be in patient care areas – environmental services staff, meal delivery, etc.

- Level 2 (Paragraph (f)(4)): The second tier of training would be designated for employees assigned with direct patient/client/resident care duties in non-high-risk services and their supervisors. These include employees who provide healthcare or social assistance services directly to patients or clients and have hands-on or face-to-face contact with patients. These employees would include nurses, nursing assistants, patient care assistants, physicians, emergency medical services employees, and social workers providing social assistance services in clients' homes. For purposes of SBREFA, OSHA also considers security staff to belong in this category

- Level 3 (Paragraph (f)(5)): The third and more advanced tier of training would be for employees with direct patient/client/resident care duties in high-risk services and their supervisors. These employees would receive the similar training as the category of employees as described above, but the distinction would be that they are performing duties within services or service areas that OSHA or an employer has deemed to be high-risk.

- Level 4 (Paragraph (f)(6)): The fourth and most-advanced tier of training would be required for employees who are reasonably expected to respond to incidents of workplace violence and their supervisors. These employees may include, e.g., security staff or incident response team members.

Each employer would need to carefully examine all employees' job duties to determine the level of training required.

Paragraph (f)(3) contains the minimum initial requirements for Level 1 training of employees who have patient contact (not care) duties and their supervisors. OSHA expects that, at a minimum, training for employees with direct patient/client/resident contact duties (employees who perform support work that requires them to be in patient care areas – environmental services staff, meal delivery, etc.) and their supervisors must receive an introductory or general awareness level of instruction that contains the following elements:

- An accessible copy of this standard and an explanation of its contents;
- A general explanation of the risks of workplace violence that employees are reasonably anticipated to encounter in their jobs;
- How to recognize, initiate and respond to specific alerts, alarms, or other warnings about threats of workplace violence;
- The role of security personnel, if any;
- How and under which circumstances to report workplace violence incidents to law enforcement;
- An explanation of the employer's violent incident reporting system and the employer's anti-retaliatory policy;
- Resources available to employees for coping with workplace violence incidents, such as employee assistance programs;
- Standard operating procedures developed as part of the WVPP [from paragraph (c)] that are applicable to the employee's duties;
- Instruction on the use of employer-provided equipment including alarms, communication devices, and PPE, as well as the limitations of this equipment;
- How to recognize threatening behaviors in others, techniques for when and how to safely attempt to de-escalate a violent situation; and
- When and how to seek assistance to respond to potentially escalating violence.

Under paragraph (f)(4), employees with direct patient/client/resident care duties in areas other than high-risk service areas, and their supervisors would receive a more intermediate level of instruction on the content specified in (f)(3) directly above. Additionally, under paragraph (f)(4), training would also include an introduction to self-defense strategies and techniques and instruction on how and when to assist others engaged with a violent patient/client/resident or visitor. This type of training may involve role-playing, simulations, and drills.

Under paragraph (f)(5), employees assigned with direct patient/client/resident care duties *in high-risk services* would receive the intermediate training described above, plus an explanation of the policies and procedures for workplace violence incidents, as well as the demonstration of practical techniques for using them. OSHA believes this additional training is warranted because these employees are at elevated risk of workplace violence due to the duties they perform in high-risk areas. This training may include simulations and drills with respect to de-escalation, chemical and physical restraint policies, and seclusion procedures, as applicable.

Under paragraph (f)(6), employees designated to respond to a workplace violence incident and their supervisors must receive an advanced level of instruction of the training described above, in addition to all SOPs that are applicable to incident response. This training may include advanced simulations and drills with respect to de-escalation, chemical and physical restraint policies, or seclusion procedures, as applicable.

OSHA expects that through the participation in these four separate tiers of trainings, employees and supervisors will receive the knowledge, skills, and abilities necessary to collaboratively identify and respond to workplace safety and security hazards. OSHA is not at this time proposing to require any specific number of hours of training for each tier.

Annual Retraining

Paragraph (f)(7) outlines draft requirements for annual retraining of employees in all four tiers. OSHA has preliminarily selected annual training because this periodicity is consistent with many other OSHA standards (OSHA, 2007), the current requirements of the Joint Commission (Joint Commission, 2021b), and consistent with the periodicity of training mentioned in by multiple commenters to the OSHA's RFI on Prevention of Workplace Violence in Healthcare and Social Assistance (e.g., Exs. 0151-A-2, 0174, 0215, 0235, 0239). Annual retraining of these employees would include, at a minimum:

- Training on all of the SOPs developed as part of the WVPP that are applicable to the employee's duties, including any changes that have been made in the past year;
- An explanation of the employer's violent incident reporting system, including any changes to the system that have been made in the past year, and results of the reviews of the WVPP;
- Any resources available to employees for coping with workplace violence incidents, such as employee assistance programs; and
- Employees who received practical training on physical techniques and those employees' supervisors shall be provided refresher training to review the topics included in the initial

training. OSHA envisions that those employees with direct-patient care duties and employees expected to respond to workplace violence incidents, along with their supervisors, would receive annual refresher training and practical demonstration of techniques consistent with those learned in the initial training.

Training Records Retention

Finally, draft paragraph (f)(8) would require training records to be created and maintained for at least one year. These records would contain training dates, the curricula covered, names and qualifications of trainers, and names and job titles of all persons in attendance. As with other OSHA training records requirements, these records could be maintained electronically or on paper.

(g) Violent Incident Investigation and Recordkeeping

Violent Incident Investigation

Post-incident investigation is an important component of an effective violence prevention program, and the information obtained from these investigations can inform other elements of the employer's WVPP. Investigating incidents of workplace violence thoroughly can provide insight into steps that can be taken to avoid future workplace violence incidents and associated injuries. The purpose of the investigation should be to identify the "root-cause" of the incident. Employers would document the significant contributing factors of workplace violence incidents and any recommendations received, and corrective measures decided upon and taken. OSHA also expects that such documentation would be used to inform any subsequent hazard assessments conducted in their establishment.

OSHA solicits feedback on the following regulatory text regarding violent incident investigation and recordkeeping. Under draft paragraph (g)(1), employers would be required to implement and maintain a written violent incident reporting system for employees to report each workplace violent incident. As noted in the definitions section, workplace violence incident means any violent act (including physical assault and threat of physical assault) directed toward persons at work or on duty by patients or their visitors. It may or may not result in injury.

Paragraph (g)(1)(i) would require covered employers to include procedures for employees to report a violent incident, a threat, or the existence of other workplace violence hazards at the site of patient/client/resident care in their violent incident reporting system. These would include incidents where no injury has occurred, such as a near-miss. These reports would be collected during an employee's normally-scheduled working shift and would not require employees to take personal time during their off-hours.

Paragraph (g)(1)(ii) would require employers to include policies and procedures that prohibit the employer, or any other person, from discriminating or retaliating against an employee who reports a workplace violence incident. OSHA is considering this requirement to ensure that employees feel comfortable reporting workplace violence incidents.

Paragraph (g)(2) contains draft requirements for violent incident investigations. It would require an employer to establish procedures for investigating the circumstances surrounding each workplace violence incident and obtaining information from the employee(s) who experienced or observed the incident.

Paragraph (g)(2)(i) would require an employer to initiate an investigation as soon as practicable, but no later than 24 hours after notification that a workplace violence incident has occurred. In this time, the employer must conduct an investigation of each incident that includes, at least:

- A review of the circumstances of the incident;
- A determination of whether any controls or measures implemented pursuant to the WVPP were ineffective;
- A determination of whether additional measures could have prevented the incident;
- Determination of whether there is a continuing hazard, and if so, what measures are being taken to protect employees, using modifications of engineering controls, work practice controls, training, or other measures; and
- Solicitation of input from involved employees, their representatives (if applicable), and supervisors, about any significant contributing factors to the incident, risk, or hazard, and whether further corrective measures could have prevented the incident, risk, or hazard.

Paragraph (g)(2)(ii) would require that covered employers document the significant contributing factors, recommendations, and corrective measures taken for each investigation conducted under this paragraph, and incorporate into the additional hazard assessment as required in paragraph (d)(4) Additional hazard assessments.

Paragraph (g)(3) would require that, following a workplace violence incident in a service area or activity not previously identified as high-risk, the employer would need to assess the service area at issue and job functions or activities that may have placed employees at increased risk for workplace violence.

Paragraph (g)(3)(i) explains that any service or area with a workplace violence incident should be considered high-risk unless there is a written determination of why this designation is not appropriate.

Reassessments – Incidents of Workplace Violence Occurring in Service Areas Not Previously Identified as High-Risk

Paragraph (g)(3)(ii) explains that, when a service or area is newly-determined to be high-risk, the employer must conduct a reassessment of the area consistent with the assessment in paragraph (d)(4)(i) Additional hazard assessments – which in effect consists of a hazard assessment of the service area at issue for environmental hazards as consistent with in (d)(1)(vi), and implementation of the controls identified in paragraph (e)(2) and (e)(3).

Paragraph (g)(3)(ii) explains that this reassessment must be conducted within 30 days unless the employer demonstrates it is infeasible, in which case it must be completed as soon as possible.

Recordkeeping

OSHA is considering a series of provisions that would form the basis for the violent incident recordkeeping and evaluation component of the WVPP. Accurate records of injuries, illnesses, and workplace violence incidents (including those where the employee did not sustain an injury), can help employers better address the workplace violence hazard. These records also help employers identify any developing trends or patterns in particular locations, jobs, or departments. These data can allow employers to evaluate methods of hazard control, identify training needs, and develop solutions for an effective prevention program. Recordkeeping and evaluating the violence prevention program are necessary to determine its overall effectiveness and identify any deficiencies or changes that should be made.

Paragraph (g)(4) describes potential requirements for employers to maintain a violent incident log. OSHA defines the violent incident log as the systematic and ongoing documentation of each incident reported through the violent incident reporting system. The employer would be required to establish and maintain records of each workplace violence incident, by establishment and by relevant patient or client care unit, regardless of whether the incident meets the criteria for an OSHA recordable injury or illness under 29 CFR Part 1904 Recordkeeping and Reporting Occupational Injuries and Illnesses. In other words, this log is completely separate from the recordkeeping requirements of 29 CFR Part 1904.

For example, this new log would include a situation where a patient/client/resident swung an object at a healthcare provider and missed or threatened to hurt an employee. OSHA's draft definition of workplace violence incident includes threats and near misses that do not result in injury. Although these incidents would not be recordable under 29 CFR Part 1904, they would need to be recorded on the violent incident log.

Paragraph (g)(4)(i) outlines specific draft requirements under consideration for the violent

incident log on multi-employer worksites. It specifies that the host employer would be required to record violent incidents affecting any contractors, vendors, staffing agencies, and licensed independent practitioners with privileges operating in the establishment.
Paragraph (g)(4)(ii) outlines potential elements that the violent incident log would be required to include. These include:

(A) Employee's name(s);
(B) Hire date(s);
(C) The date, time, and location of the incident, and job titles of involved employee(s);
(D) A detailed description of the incident;
(E) A description of risk factors present at the time of the incident (e.g., whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, in a high crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances);
(F) The nature and extent of the employee's injuries, if any;
(G) Whether the incident required medical attention;
(H) Whether there was injury requiring days away from work;
(I) Name of person(s) who committed the violence;
(J) Classification of the person(s) who committed the violence, including whether they were a patient or client, family member or associate of a patient or client, or any other appropriate classification; and
(K) Information about the person completing the log including their name, job title, phone number, email address, and the date completed.

Paragraph (g)(4)(iii) would require that certain information from the violent incident log be available upon request to all employees:

(A) The nature and extent of the employee's injuries, if any;
(B) A detailed description of the incident;
(C) The date, time, and location of the incident, and job titles of involved employee(s);
(D) A description of risk factors or other circumstances at the time of the incident.
(E) Classification of the person(s) who committed the violence, including whether they were a patient or client, family member or associate of a patient or client, or any other appropriate classification; and
(F) This information relating to employee health must be used in a manner that protects the confidentiality of employees to the extent possible. The employer must omit any element of personal identifying information sufficient to allow identification of any person involved in a workplace violence incident, such as the person's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the person's identity.

OSHA does not intend to stipulate whether employers with multiple units are required to create individual incident logs on a unit-by-unit basis in addition to reporting into a centralized source. OSHA recognizes that many large employers might find that added benefits of effectiveness and

accuracy could occur through the maintenance and review of individual units providing specific services within varied locations, but OSHA leaves this discretion to the employer.

OSHA expects that the controlling host employer would also record violent incidents affecting any contractors, vendors, staffing agencies, and licensed independent practitioners with privileges operating on the premises not only on the host employer's OSHA 300 Log, but also on the controlling host employer's violent incident log. Additionally, the host employer would train, discuss, and communicate with both the contracted employees and the contracted employer the details of the WVPP for their establishment.

(h) Retention of Records

OSHA solicits feedback on the use of the below draft regulatory text on retention of records. Consistent with other OSHA standards, OSHA is considering a requirement that all records required by this section shall be provided upon request to employees, representatives designated by an individual employee, and the Assistant Secretary.

Paragraph (h)(1)(i) presents a draft requirement that records of annual WVPP reviews as required by paragraph (c), must be created and maintained for a minimum of three years.

Paragraph (h)(1)(ii) presents a draft requirement that records of workplace violence hazard assessment and control measures as required in paragraphs (d) and (e), Table E-1, or Table E-2, as applicable, must be created and maintained for three years, or for as long as there is an unresolved hazard mitigation project pending or still in progress.

Paragraph (h)(1)(iii) presents a draft requirement that training records as required in paragraph (f) must be created and maintained for a minimum of one year.

Paragraph (h)(1)(iv) presents a draft requirement that records of violent incidents, including violent incident investigation reports and violent incident log reports required by this paragraph be created and maintained for a minimum of three years. This paragraph further would require that:

(A) Establishment-wide violent incident records shall be provided to the Assistant Secretary upon request within next business day.

(B) Establishment-wide violent incident log reports, excluding employee names, contact information, and occupations, shall be provided to all of the following: any employees, their personal representatives, and their authorized representatives within the next business day.

(C) Violent incident records relating to a particular employee shall be provided to that employee and to anyone having written authorized consent of that employee within the next business day.

Consistent with other OSHA standards, OSHA expects that records required by this section would be provided upon request to employees, former employees, representatives designated by an individual employee, and the Assistant Secretary. OSHA also emphasizes that the violent incident reporting system shall not replace the employer's obligations to comply with OSHA's Recordkeeping and Reporting requirements in 29 CFR Part 1904. Injuries or illnesses that occur as a result of workplace violence may also be recordable on the OSHA 300 log. Work-related injuries or illnesses are recordable if they result in death, medical treatment beyond first aid, loss of consciousness, transfer to another job, or restriction of work (restricted work activity or days away from work). *See* 29 CFR 1904.7(a).

Paragraph (h) includes a note to clarify that the violent incident investigation reports and violent incident logs, as described a above, do NOT replace the requirements for employers to comply with 29 CFR Part 1904.

(i) Anti-Retaliation

Paragraph (i)(1) would require employers to inform each employee that employees have a right to the protections required by this section, and that employers are prohibited from discharging or in any manner discriminating against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.

Paragraph (i)(2) would require that employers not discharge or in any manner discriminate against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.

Paragraph (i) includes a note to clarify that section 11(c) of the OSH Act also prohibits employers from discriminating against an employee for exercising rights under, or as a result of actions that are required by, this section. Section 11(c) also protects employees who file a safety and health complaint, or otherwise exercise any rights afforded by the OSH Act.

(j) Effective Date of the Draft Standard

OSHA's draft standard indicates that all of the provisions of the final standard would become effective sixty days after the publication date. Employers would be expected to comply with all provisions of the final standard within six months after the publication date to provide adequate time for training, control implementation, and other compliance.

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Section V. Industry Profile, Costs of Compliance, WPV Incident Analysis

Table of Contents

List of Tables

1. Industry Profile

1.1 Introduction

This chapter describes and estimates affected employers and workers in the Health Care and Social Assistance industry sector covered by the regulatory framework. The industry profile provides the number of entities, establishments, and employees in the covered subsectors, as well as corresponding breakdowns for small entities and very small entities.[11] This chapter presents summary statistics of the profile. Refer to Appendix A for the underlying detailed methodology.

1.2 Scope of the Regulatory Framework

The draft standard applies to all employers with employees that work in:

- **Hospitals, including emergency departments.** This refers to general medical, surgical, and specialty hospitals primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with a wide variety of medical conditions. These establishments maintain inpatient beds and provide patients with food services. These hospitals have an organized staff of physicians and other medical staff to provide patient care services. This includes ambulatory services that are provided on hospital grounds;
- **Behavioral health care facilities**, including 1) psychiatric hospitals and residential behavioral health facilities, and 2) ambulatory mental health care and ambulatory substance abuse treatment centers. Psychiatric hospital means a hospital primarily engaged in providing diagnostic, medical treatment, and monitoring services for inpatients with mental illness or substance abuse disorders. Treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services. Ambulatory mental health facilities and ambulatory substance abuse centers primarily provide mental health services on an outpatient basis and include facilities such as offices of psychiatrists, psychologists, mental health specialists, mental health practitioners, or substance abuse centers;
- **Residential care facilities** provide residential care combined with nursing, supervisory, or other types of assistance as required by the residents. These include establishments providing inpatient nursing and rehabilitative services, where such care is generally provided for an extended period of time. These establishments have a permanent core staff of registered or licensed practical nurses who, along with other staff, provide nursing and continuous personal care services. This setting also includes establishments providing residential and personal care services for (1) the elderly and other persons who

[11] "Entities" include private firms, nonprofits, and government organizations. An "establishment" is a single physical workplace. An entity may have multiple establishments. In this PIRFA, OSHA's criteria for defining entities as "small" are based upon the U.S. Small Business Administration (SBA) size standards in accordance with the Regulatory Flexibility Act (RFA) as amended by the Small Business Regulatory Enforcement Fairness Act (SBREFA). "Very small entities" are defined in this PIRFA as enterprises with fewer than twenty employees.

are unable to care for themselves independently and/or (2) the elderly and other persons who do not desire to live independently. The care typically includes room, board, supervision, and assistance in daily living, such as housekeeping services. In some instances, these establishments provide skilled nursing care for residents in separate on-site facilities. These establishments generally provide a wide range of social services in addition to counseling; [12]

- **Home health care**, including home-based social assistance. This includes any care or services provided at the patient/client/resident's residence;
- **Social assistance**, where social assistance services are directly provided. This excludes child day care centers; and,
- **Emergency medical services**, including paramedics, emergency medical technicians (EMTs), and firefighters cross-trained and performing services as paramedics or EMTs.

Table 1 summarizes the individual NAICS codes covered by the scope of the draft standard in these six overall Healthcare Settings. [13]

Table 1. Healthcare Settings, by NAICS Code

Healthcare Setting	NAICS Description	NAICS Code
Residential Behavioral Health Facilities	Offices of Physicians, Mental Health Specialists	621112
	Offices of Mental Health Practitioners (except Physicians)	621330
	Outpatient Mental Health and Substance Abuse Centers	621420
	Psychiatric hospitals	622210
	Residential Intellectual and Developmental Disability Facilities	623210
	Residential Mental Health and Substance Abuse Facilities	623220
Hospitals, other than mental health	General medical and surgical hospitals	622110
	Freestanding Ambulatory Surgical and Emergency Centers	621493
	Specialty (except psychiatric and substance abuse) hospitals	622310
Residential Care Facilities	Nursing care facilities (skilled nursing facilities)	623110
	Continuing Care Retirement Communities	623311
	Assisted Living Facilities for the Elderly	623312
	Other Residential Care Facilities	623990
Home Healthcare Services	Home health care services	621610
	Services for the Elderly and Persons with Disabilities	624120
Social Assistance	Child and Youth Services	624110
	Other Individual and Family Services	624190

[12] These establishments do not include Residential Intellectual and Developmental Disability Facilities or Residential Mental Health and Substance Abuse Facilities, both of which are included in the scope of the behavioral health care facility setting.

[13] Though most tables in this section are presented for these general healthcare settings, it is important to note that all calculations are actually done at the more detailed NAICS industry level and by ownership (private, non-profit, and government), and then aggregated to healthcare settings for presentation. Industry level tables are aggregated over ownership. See Appendix A for more results at the industry and industry-ownership level.

Healthcare Setting	NAICS Description	NAICS Code
	Community Food Services	624210
	Temporary Shelters	624221
	Other Community Housing Services	624229
	Emergency and Other Relief Services	624230
	Vocational Rehabilitation Services	624310
Emergency Medical Services	Ambulance Services	621910
	Firefighter-EMTs	*

* NAICS 922160 includes government and volunteer firefighters, including those cross-trained as EMTs. Potentially affected private sector firefighter-EMTs are in entities typically classified under NAICS 561990. See Appendix A for discussion of how OSHA developed the profile this group.
Source: OSHA, 2023.

1.3 Potentially Regulated Entities

OSHA uses a combination of data from the U.S. Census Bureau's County Business Patterns (CBP), Bureau of Labor Statistics' Quarterly Census of Employment and Wages (QCEW), and other sources to characterize potentially regulated firms, establishments, employees, and annual revenues. Some state- and local-government entities are outside of OSHA jurisdiction (those not in state-plan states) and are excluded from this analysis. Appendix A details OSHA's methodology for constructing estimates using these data sources.

Table 2 summarizes the set of entities covered by the regulatory framework. OSHA estimates that approximately 201,700 entities would be subject to a workplace violence rule, including approximately 300,400 establishments and 14 million employees.

Table 2. Summary of Potentially Regulated Entities

Healthcare Setting	Behavioral Health Facilities	Hospitals, other than mental health	Residential Care Facilities	Home Healthcare Services	Social Assistance	Emergency Responders	Total
For profit							
Entities	41,202	4,777	24,289	39,132	9,828	2,332	121,561
Establishments	58,344	8,754	37,589	52,714	13,744	4,187	175,332
Employees	597,823	948,597	1,957,969	1,980,102	119,947	157,703	5,762,141
Non-Profit							
Entities	11,460	1,995	6,254	11,931	35,755	995	68,391
Establishments	32,549	4,187	9,845	15,432	49,568	1,787	113,368
Employees	748,537	3,902,235	760,479	652,066	990,072	43,441	7,096,830
State and Local Government							
Entities	2,007	925	697	510	1,799	5,808	11,747
Establishments	2,007	925	697	510	1,799	5,808	11,747
Employees	137,072	528,797	44,190	27,281	91,213	265,303	1,093,856
Total							
Entities	54,670	7,697	31,240	51,573	47,382	9,136	201,698
Establishments	92,900	13,866	48,131	68,656	65,111	11,782	300,447
Employees	1,483,432	5,379,629	2,762,638	2,659,449	1,201,232	466,447	13,952,827

Source: OSHA, 2023, based on CBP (2019a and 2019b), BLS (2018), USFA (2018).
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

1.4 Potentially Regulated Small Entities

This PIRFA will present costs and impacts for the following categories of entities based on *size*:

- All in-scope entities,
- Small entities, as defined by U.S. Small Business Administration (SBA) size standards in accordance with the Regulatory Flexibility Act (RFA) as amended by the Small Business Regulatory Enforcement Fairness Act (SBREFA), and
- Very small entities, defined as entities having fewer than 20 employees.

The SBA's Table of Small Business Size Standards defines small business thresholds for each NAICS industry (SBA, 2019). These thresholds are entity-level (versus establishment) and, for private firms, depend on the industry and are generally based on either a firm's total number of employees or total annual revenue. For in-scope private firms, all of the SBA small business thresholds are revenue-based, ranging from $8.0 to $41.5 million per year depending on the NAICS industry. Table 3 presents SBA-defined small entity/business thresholds for potentially affected NAICS industries.

Table 3. SBA Small Entity Thresholds for In-Scope NAICS Industries, Private Entities

Healthcare Setting	NAICS Description	NAICS Code	SBA Small Business Threshold (Revenue, $Millions)
Behavioral Health Facilities	Outpatient Mental Health and Substance Abuse Centers	621420	$16.5
	Psychiatric and substance abuse hospitals	622210	$41.5
	Offices of Physicians, Mental Health Specialists	621112	$12.0
	Offices of Mental Health Practitioners (except Physicians)	621330	$8.0
	Residential intellectual and developmental disability	623210	$16.5
	Mental health, and substance abuse facilities	623220	$16.5
Hospitals, other than mental health	General medical and surgical hospitals	622110	$41.5
	Freestanding Ambulatory Surgical and Emergency Centers	621493	$16.5
	Specialty (except psychiatric and substance abuse)	622310	$41.5
Residential Care Facilities	Nursing care facilities (skilled nursing facilities)	623110	$30.0
	Continuing Care Retirement Communities	623311	$30.0
	Assisted Living Facilities for the Elderly	623312	$12.0
	Other residential care facilities	623990	$12.0
Home Healthcare	Home health care services	621610	$16.5
Social Assistance Facilities	Child and Youth Services	624110	$12.0
	Other Individual and Family Services	624190	$12.0
	Community Food Services	624210	$12.0
	Temporary Shelters	624221	$12.0
	Other Community Housing Services	624229	$16.5

Healthcare Setting	NAICS Description	NAICS Code	SBA Small Business Threshold (Revenue, $Millions)
	Emergency and Other Relief Services	624230	$35.0
	Vocational Rehabilitation Services	624310	$12.0
Emergency Responders	Ambulance Services	621910	$16.5
	All Other Support Services	561990	$12.0

Source: SBA (2019).

The RFA defines small nonprofit organizations as those that are not dominant in their field, and small governmental jurisdictions (sometimes referred to as "small governments" in this analysis) as those that serve a population of less than 50,000.[14] For purposes of SBREFA and other analyses directed by the RFA, OSHA considers all nonprofits as fitting the RFA definition of small non-profits. For government organizations, local-government entities that are located in counties with population under 50,000 are the basis for estimating RFA-defined small governments.[15]

The third set of estimates for very small entities (those with fewer than 20 employees) were obtained from the 2017 CBP data, as described in Appendix A.

Table 4 presents, for each healthcare setting, the number of entities, establishments, and employees by size category: all sizes, SBA/RFA-defined small entities, and very small entities. These data include all ownership categories. OSHA preliminarily estimates that approximately 186,000 small entities, employing about 10 million employees, may be affected by this potential rule. Of these SBA/RFA-defined small entities, 128,000 are very small entities employing fewer than 20 people. Nearly 572,000 employees work for very small entities covered by this potential rule.

Table 4. In-Scope Total, Small, and Very Small Entities

Healthcare Setting	All Sizes	SBA/RFA-Defined Small	Very Small
Entities			
Behavioral Health Facilities	54,670	52,174	42,934
Hospitals, other than mental health	7,697	6,277	2,746
Residential Care Facilities	31,240	29,434	15,897
Home Healthcare Services	51,573	50,020	32,108
Social Assistance Facilities	47,382	45,614	33,460
Emergency Responders	9,136	8,497	2,643
Total	201,698	192,016	129,788
Establishments			
Behavioral Health Facilities	92,900	81,576	43,389

[14] See "A Guide for Government Agencies: How to Comply with the Regulatory Flexibility Act," SBA, Office of Advocacy, May 2012.

[15] Even though OSHA considers all non-profits, regardless of revenue size, to be small entities according to the RFA definition, OSHA also keeps track of which non-profit entities meet the revenue criteria applied to for-profit entities so that entities are differentiated by the size of their operation (versus RFA designation) for the purposes of costing. Many cost inputs in the analysis are a function of facility size, so OSHA wants to maintain this characterization of non-profit entities for the cost analysis.

Healthcare Setting	All Sizes	SBA/RFA-Defined Small	Very Small
Hospitals, other than mental health	13,866	8,743	2,766
Residential Care Facilities	48,131	35,367	16,235
Home Healthcare Services	68,656	57,684	32,245
Social Assistance Facilities	65,111	61,841	34,267
Emergency Responders	11,782	9,794	2,678
Total	300,447	255,005	131,580
Employees			
Behavioral Health Facilities	1,483,432	1,106,995	129,301
Hospitals, other than mental health	5,379,629	4,068,452	18,897
Residential Care Facilities	2,762,638	1,700,716	86,876
Home Healthcare Services	2,659,449	1,744,657	151,505
Social Assistance Facilities	1,201,232	1,077,556	159,861
Emergency Responders	466,447	282,999	25,409
Total	13,952,827	9,981,375	571,849

Source: OSHA, 2023, based on CBP (2019a and 2019b), SBA (2019).
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

1.5 Direct Patient/Client/Resident Care and Contact Employees

The regulatory framework distinguishes between general employees covered by the draft rule and those who are at greater risk and are required to receive specific training on workplace violence. The framework requires training for each worker who provides direct patient/client/resident care, has direct patient/client/resident contact, has workplace violence incident response duties, and their supervisory staff:

- **Direct patient/client/resident care** means job duties that involve the delivery of healthcare services or social assistance services with hands-on or face-to-face contact with patients or clients. Workers who provide direct patient/client/resident care include nurses, physicians, technicians, home care workers visiting client homes, as well as workers providing emergency medical services.
- **Direct patient/client/resident contact** means job duties where workers perform support work that requires them to be in patient/client/resident care areas. Such work includes housekeeping, maintenance, meal delivery, and information technology. For purposes of SBREFA, OSHA also considers security staff to belong in this category.

To estimate the number of direct patient/client/resident care and contact (PCCC) employees for each healthcare setting, OSHA uses the Bureau of Labor Statistics' (BLS) most recent Occupational Employment Statistics (OES) dataset, which provides NAICS-specific estimates of employment *by occupation* (BLS, 2019). Within the general Healthcare and Social Assistance sector, OES includes 485 unique occupations, including both healthcare and non-healthcare occupations. Of these, OSHA identified 80 occupations that fit within the definition for direct patient/client/resident care, 10 occupations with direct patient/client/resident contact (but not care), and 10 occupations of associated supervisory staff, based on a review of BLS' occupation descriptions. The list of occupations is included in Appendix B to this report. OSHA then

calculated the proportion of employees in these categories for each NAICS code. OSHA assumes that all employees in facilities with five or fewer total employees are direct patient/client/resident care and contact employees.

Table 5 presents the resulting estimates of the number of direct patient/client/resident care and contact employees, by healthcare setting. There is a range of 66 to 86 percent of employees in the affected settings working in these occupations, with the large majority being patient/client/resident care (versus contact-only). The home healthcare setting has the highest individual proportion of employees in direct patient/client/resident care occupations of the six settings, at 86 percent of employees, while social assistance is the lowest at 66 percent. OSHA estimates that approximately 10.4 million in-scope employees work in direct PCCC occupations. Approximately 3.8 million PCCC employees work in SBA-defined small business entities and about 487,000 PCCC employees are in very small entities.

Table 5. Employees in Direct Patient/client/resident Care or Contact (PCCC) Occupations

Setting and Ownership	Percent of Employees in Care or Contact Occupations	Direct Care Occupation Employees	Direct Contact Occupation Employees	Total Direct Care or Contact Occupation Employees	Total Direct Care or Contact Employees in SBA/RFA-Defined Small Entities	Total Direct Care or Contact Employees in Very Small Entities
Behavioral Health Facilities	67%	1,089,039	76,732	1,165,771	607,323	113,405
Hospitals, other than mental health	68%	3,356,951	276,339	3,633,291	239,493	12,097
Residential Care Facilities	78%	1,756,197	403,694	2,159,892	1,035,269	66,345
Home Healthcare Services	86%	2,269,836	20,688	2,290,524	1,271,399	142,468
Social Assistance Facilities	66%	710,122	61,173	771,295	506,040	132,775
Emergency Responders	79%	363,801	142	363,943	205,396	19,881
	Total	9,545,947	838,768	10,384,715	3,864,921	486,971

Source: OSHA, 2023, based on BLS (2019).
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

Direct patient/client/resident care/contact employees are employees at higher risk of workplace violence due to their closer proximity and work with the serviced population. In Appendix B, OSHA presents the occupations identified by the agency as direct patient/client/resident care/contact employees. To calculate employment shares of these categories by industry, OSHA uses the Bureau of Labor Statistics' (BLS) most recent Occupational Employment Statistics (OES), which provides industry-specific estimates of employment *by occupation* (BLS, 2019). For each NAICS code, OSHA estimated the proportion of employees in patient/client/resident care and patient/client/resident contact occupations, including their supervisors, and applied these industry-level proportions to the CBP-based estimates of employment. This resulted in estimates of the number of employees, by industry, in these specific occupations.

Table 6 presents the estimated number of patient/client/resident care and contact employees per establishment for each ownership category: for-profit, non-profit, state government, and local government establishments, respectively. These data are key inputs for the analyses of unit costs

for provisions in the draft rule affecting PCCC employees. As noted earlier in this section, the draft regulatory framework requires training for each worker who provides direct patient/client/resident care, has direct patient/client/resident contact, has workplace violence incident response duties, and their supervisory staff. Section 2.5 below discusses OSHA's methodology for assigning unit training hours to PCCC employees, employees with workplace violence incident response duties, and supervisory staff in the agency's training cost model.

Table 6. Number of Direct Patient/Client/Resident Care or Contact Employees per Facility

NAICS	NAICS Description	Direct Patient/Client/Resident Care/Contact Employees per Facility		
		Large	SBA/RFA-Defined Small	Very Small
For-Profit Facilities				
621112	Offices of Physicians, Mental Health Specialists	NA	3	2
621330	Offices of Mental Health Practitioners (except Physicians)	NA	4	2
621420	Outpatient Mental Health and Substance Abuse Centers	15	9	4
621493	Freestanding Ambulatory Surgical and Emergency Centers	18	10	5
621610	Home Health Care Services	68	23	5
621910	Ambulance Services	41	26	6
622110	General Medical and Surgical Hospitals	522	80	3
622210	Psychiatric and Substance Abuse Hospitals	267	126	4
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	125	52	2
623110	Nursing Care Facilities (Skilled Nursing Facilities)	92	68	4
623210	Residential Intellectual and Developmental Disability Facilities	13	12	5
623220	Residential Mental Health and Substance Abuse Facilities	36	18	4
623311	Continuing Care Retirement Communities	61	29	5
623312	Assisted Living Facilities for the Elderly	40	12	4
623990	Other Residential Care Facilities	15	8	5
624110	Child and Youth Services	19	8	4
624120	Services for the Elderly and Persons with Disabilities	92	23	4
624190	Other Individual and Family Services	14	4	2
624210	Community Food Services	7	4	4
624221	Temporary Shelters	NA	6	4
624229	Other Community Housing Services	NA	3	3
624230	Emergency and Other Relief Services	4	2	2
624310	Vocational Rehabilitation Services	14	7	4
	Firefighter-EMTs	350	27	11
Non-Profit Facilities				
621112	Offices of Physicians, Mental Health Specialists	NA	10	4
621330	Offices of Mental Health Practitioners (except Physicians)	NA	6	4
621420	Outpatient Mental Health and Substance Abuse Centers	33	18	4
621493	Freestanding Ambulatory Surgical and Emergency Centers	27	15	5
621610	Home Health Care Services	126	42	6
621910	Ambulance Services	26	17	8
622110	General Medical and Surgical Hospitals	1028	157	3
622210	Psychiatric and Substance Abuse Hospitals	323	152	NA
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	355	149	3
623110	Nursing Care Facilities (Skilled Nursing Facilities)	119	88	6
623210	Residential Intellectual and Developmental Disability Facilities	18	16	6
623220	Residential Mental Health and Substance Abuse Facilities	33	17	5
623311	Continuing Care Retirement Communities	207	97	7

Table 6. Number of Direct Patient/Client/Resident Care or Contact Employees per Facility

NAICS	NAICS Description	Direct Patient/Client/Resident Care/Contact Employees per Facility		
		Large	SBA/RFA-Defined Small	Very Small
Non-Profit Facilities				
623312	Assisted Living Facilities for the Elderly	49	15	5
623990	Other Residential Care Facilities	32	17	5
624110	Child and Youth Services	30	12	5
624120	Services for the Elderly and Persons with Disabilities	92	23	5
624190	Other Individual and Family Services	38	12	5
624210	Community Food Services	7	4	4
624221	Temporary Shelters	NA	10	4
624229	Other Community Housing Services	NA	7	3
624230	Emergency and Other Relief Services	23	4	4
624310	Vocational Rehabilitation Services	38	19	3

NAICS	NAICS Description	Patient/Client Care/Contact/Resident Employees per Facility	
		Large	Very Small
State-Government Facilities			
621112	Offices of Physicians, Mental Health Specialists	14	9
621330	Offices of Mental Health Practitioners (except Physicians)	NA	NA
621420	Outpatient Mental Health and Substance Abuse Centers	25	5
621493	Freestanding Ambulatory Surgical and Emergency Centers	11	4
621610	Home Health Care Services	34	5
621910	Ambulance Services	NA	NA
622110	General Medical and Surgical Hospitals	1336	5
622210	Psychiatric and Substance Abuse Hospitals	59	1
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	207	3
623110	Nursing Care Facilities (Skilled Nursing Facilities)	123	6
623210	Residential Intellectual and Developmental Disability Facilities	65	23
623220	Residential Mental Health and Substance Abuse Facilities	36	8
623311	Continuing Care Retirement Communities	98	7
623312	Assisted Living Facilities for the Elderly	7	2
623990	Other Residential Care Facilities	28	7
624110	Child and Youth Services	46	13
624120	Services for the Elderly and Persons with Disabilities	131	16
624190	Other Individual and Family Services	65	18
624210	Community Food Services	NA	NA
624221	Temporary Shelters	NA	NA
624229	Other Community Housing Services	NA	NA
624230	Emergency and Other Relief Services	NA	NA
624310	Vocational Rehabilitation Services	9	2
	Firefighter-EMTs	37	10

Table 6. Number of Direct Patient/Client/Resident Care or Contact Employees per Facility

NAICS	NAICS Description	Direct Patient/Client/Resident Care/Contact Employees per Facility		
		Large	SBA/RFA-Defined Small	Very Small
Local-Government Facilities				
621112	Offices of Physicians, Mental Health Specialists	17	2	NA
621330	Offices of Mental Health Practitioners (except Physicians)	37	3	2
621420	Outpatient Mental Health and Substance Abuse Centers	86	14	5
621493	Freestanding Ambulatory Surgical and Emergency Centers	87	10	5
621610	Home Health Care Services	53	24	5
621910	Ambulance Services	28	18	6
622110	General Medical and Surgical Hospitals	580	135	3
622210	Psychiatric and Substance Abuse Hospitals	199	94	NA
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	96	NA	NA
623110	Nursing Care Facilities (Skilled Nursing Facilities)	276	71	4
623210	Residential Intellectual and Developmental Disability Facilities	40	14	5
623220	Residential Mental Health and Substance Abuse Facilities	26	17	5
623311	Continuing Care Retirement Communities	51	24	5
623312	Assisted Living Facilities for the Elderly	15	4	4
623990	Other Residential Care Facilities	38	14	4
624110	Child and Youth Services	78	11	5
624120	Services for the Elderly and Persons with Disabilities	38	23	4
624190	Other Individual and Family Services	89	10	4
624210	Community Food Services	5	3	4
624221	Temporary Shelters	NA	6	4
624229	Other Community Housing Services	7	6	3
624230	Emergency and Other Relief Services	6	4	4
624310	Vocational Rehabilitation Services	20	10	5
	Firefighter-EMTs	165	23	10

Source: OSHA, 2023. NA = no establishments. There are no establishments that qualify as small entities under the RFA definitions.

2. Unit Costs

Compliance cost estimates for each of the requirements under the potential rule are detailed in the following sections. Several sources were used to derive these estimates, including publicly-available data from federal agencies and other sources (e.g., trade associations), as well as conversations with industry sector subject matter experts. Agency judgment was also used when no available data source could be found.

Many employers are already taking a number of measures that would be required by the potential rule even absent a new regulation. OSHA considers this level of compliance to constitute the "baseline" from which additional costs are measured. OSHA's analysis of total costs accounting for baseline compliance activity is described in Chapter 3.

The unit cost estimates presented here are "from scratch," as if an affected employer had no cost elements in place. For example, the unit cost of a hazard assessment is calculated based on the average amount of time it would take to perform the assessment based on facility type and size and other factors. This is a fixed average cost; OSHA does then reduce that unit cost to account for the fact that some employers may have already gathered some of the information necessary for the hazard assessment. If OSHA determines that certain employers are already performing the full hazard assessment even before required to do so by an OSHA standard, then this will constitute baseline compliance and OSHA would not apply a cost to those employers. But anything less than full compliance will result in a full unit cost applied to that employer.

In the cost analysis, OSHA often compares "large" and "small" facility types. OSHA uses RFA's definition of small entity or organization *except* that OSHA considers all non-profit entities to be small (SBA, 2019). Because the RFA's definition for small non-profit organizations is that they be not dominant in their field, all non-profit organizations, including very large organizations, are considered small by this SBA criterion. For purposes of estimating cost impacts, OSHA assigned the private for-profit size criteria to non-profit entities in the applicable affected NAICS groups and for analytical convenience the agency applied the SBA revenue thresholds to small non-profit entities. By mapping the size distribution patterns of private entities to non-profit entities, OSHA could then apply per-entity revenue estimates to non-profits from the overall revenue distribution for private entities published in the 2017 CBP See Appendix A for more details. [16]

[16] County Business Patterns (CBP) is an annual series published by the U.S. Census Bureau that provides subnational economic data by industry. The CBP series includes the number of establishments, employment during a given week, first quarter payroll, and annual payroll.

As discussed in Appendix A, the 2017 CBP data include entity revenue by employment size category. OSHA uses these data to estimate the average revenue per firm, by NAICS code and employment-size category. OSHA first identifies the SBA-designated revenue threshold for each NAICS. Next, OSHA aggregates the number of firms across employment-sizes for all firms with average revenue below the applicable SBA revenue threshold. The result of that calculation was the number of SBA-defined small private firms by NAICS code. For this PIRFA, OSHA estimated the percentage of firms that are small for each NAICS code, and applied that percentage to the number of affected for-profit entities to estimate the number of affected small for-profit entities. To estimate the number of affected small non-profit entities, OSHA applied the simplifying assumption that revenue distribution patterns among non-profit entities were identical to those among for-profit entities.

2.1 Labor Rates

All of the potential rule's provisions include compliance elements that require a labor burden for regulated entities, which is monetized using labor rates for relevant occupations associated with any given compliance activity. To estimate wages and total labor rates, OSHA used the BLS OES, which provides average wage rates by NAICS industry and occupation (BLS, 2019).

OSHA estimated weighted-average hourly wages, by NAICS code, for all employees and subsets of occupations required for the analysis, including supervisors and managers, direct patient/client/resident care and contact employees, and training specialists. The average wages for "patient/client/resident care," "patient/client/resident contact," "supervisor/manager," and "training specialist" employees were determined by taking the weighted average of wages of BLS Standard Occupational Classification (SOC) occupational classifications within each of those four employee groups. For the details on the calculation of weighted averages for the four occupation categories noted above, see OSHA, 2022 [Excel workbook], tab "Occupation and Wages", columns R-V, and tab "BLS OES 2018."

Supervisor/manager wages reflect the diversity of key leadership anticipated to participate in the compliance activities under the potential rule, such as the development of policies and procedures, implementation of hazard assessments, participation in training, incident response, investigation of incidents, and other elements as specified in subsequent sections of this chapter. As described earlier in this Industry Profile (Section 1.5, above), OSHA identified 80 occupations that fit within the definition for direct patient care and 10 occupations associated with direct patient contact (but not care), based on a review of BLS' occupation descriptions. See Appendix B for a list of occupations included for supervisors and direct/client care and contact employees.

OSHA estimated total labor rates by adjusting base wages to account for other employer labor costs, including benefits and other direct employer obligations. The agency's estimated percentages for benefits and other direct employer obligations were calculated from data reported in BLS' Employer Cost of Employee Compensation (ECEC) describing wages as a percentage of total compensation for hospitals (64.9 percent) and other healthcare settings (69.3 percent) (BLS, 2019b). For this PIRFA, OSHA calculated a "loaded wage" which included a fringe benefit rate ranging from 28 percent of total compensation to 39 percent of total compensation (depending on the healthcare setting and occupational category)[17] and an overhead rate when estimating the marginal cost of labor in its primary cost calculation. Overhead costs are indirect expenses that cannot be tied to producing a specific product or service. Common examples include rent, utilities, and office equipment. There is no general consensus on the cost elements that fit this definition, which has led to a wide range of overhead estimates. For this PIRFA, OSHA applied an overhead rate of 17 percent of base wages.[18]

[17] See OSHA, 2023 [Excel workbook], tabs "Occupations & Wages" and "BLS ECC".

[18] The methodology was modeled after an approach used by the U.S. Environmental Protection Agency. More information on this approach can be found at U.S. Environmental Protection Agency, "Wage Rates for Economic Analyses of the Toxics Release Inventory Program," June 10, 2002. This analysis was based on a survey of several large chemical manufacturing plants: Heiden Associates, *Final Report: A Study of Industry Compliance Costs Under the Final Comprehensive Assessment Information Rule*, Prepared for the Chemical Manufacturers Association, December 14, 1989. This is consistent with the overhead rate used for sensitivity analyses in the 2017 Improved Tracking Final Economic Analysis (FEA) and the FEA in support of OSHA's 2016 final standard on Occupational Exposure to Respirable Crystalline Silica.

Labor rates do not vary by entity size or ownership category. Table 7 presents total hourly labor costs by NAICS industry and employee category.

Table 7. Labor Rates for Facility Employees, by NAICS industry ($/hr.)

NAICS	NAICS Description	All Employees	Patient/ Client Care	Patient/ Client Contact	Supervisors/ Managers	Training Specialists
621112	Offices of Physicians, Mental Health Specialists	$64.94	$84.67	$23.17	$91.17	$51.58
621330	Offices of Mental Health Practitioners (except Physicians)	$50.04	$55.87	$22.82	$86.26	$51.22
621420	Outpatient Mental Health and Substance Abuse Centers	$42.09	$41.66	$22.94	$75.26	$44.21
621493	Freestanding Ambulatory Surgical and Emergency Centers	$50.07	$52.98	$23.84	$80.84	$49.78
621610	Home Health Care Services	$32.92	$30.77	$23.08	$77.17	$55.69
621910	Ambulance Services (and Firefighter-EMTs)	$32.71	$29.19	$23.35	$76.16	$48.09
622110	General Medical and Surgical Hospitals	$51.47	$55.67	$23.61	$95.53	$54.85
622210	Psychiatric and Substance Abuse Hospitals	$45.03	$46.27	$26.31	$85.40	$47.75
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	$52.73	$51.66	$23.65	$98.15	$57.27
623110	Nursing Care Facilities (Skilled Nursing Facilities)	$32.61	$33.57	$20.61	$73.46	$52.27
623210	Residential Intellectual and Developmental Disability Facilities	$25.15	$22.89	$23.42	$41.01	$37.67
623220	Residential Mental Health and Substance Abuse Facilities	$33.10	$30.97	$22.66	$60.21	$44.23
623311	Continuing Care Retirement Communities	$26.96	$26.12	$20.72	$60.09	$47.46
623312	Assisted Living Facilities for the Elderly	$26.96	$26.12	$20.72	$60.09	$47.46
623990	Other Residential Care Facilities	$29.85	$28.06	$23.37	$51.25	$42.67
624110	Child and Youth Services	$27.32	$24.52	$21.99	$53.61	$40.60
624120	Services for the Elderly and Persons with Disabilities	$24.21	$22.60	$21.29	$47.76	$37.50
624190	Other Individual and Family Services	$27.32	$24.52	$21.99	$53.61	$40.60
624210	Community Food Services	$35.26	$30.45	$23.28	$59.21	$41.78
624221	Temporary Shelters	$35.26	$30.45	$23.28	$59.21	$41.78
624229	Other Community Housing Services	$35.26	$30.45	$23.28	$59.21	$41.78
624230	Emergency and Other Relief Services	$35.26	$30.45	$23.28	$59.21	$41.78
624310	Vocational Rehabilitation Services	$29.05	$26.07	$21.58	$56.02	$36.95

Source: OSHA, 2023, based on BLS (2019a, 2019b).

Table 8 presents average hourly labor costs, aggregated to the healthcare settings.

Table 8. Labor Rates for Facility Employees, by Setting ($/hr.)

Healthcare Setting	All Covered Employees	Direct Patient/ Client Care	Direct Patient/ Client Contact	Direct Patient/ Client Care or Contact	Supervisors /Managers	WPV Training Specialist
Behavioral Health Facilities	$50.82	$58.21	$23.71	$56.68	$68.62	$45.68
Hospitals, other than mental health	$51.51	$55.47	$23.61	$53.01	$95.37	$54.89
Residential Care Facilities	$30.50	$31.05	$20.82	$29.13	$65.85	$49.55
Home Healthcare Services	$28.09	$26.25	$21.63	$26.20	$58.39	$44.20
Social Assistance Facilities	$28.80	$25.18	$22.18	$24.96	$55.50	$38.43
Emergency Responders	$32.71	$29.19	$23.35	$29.18	$76.16	$48.09

Source: BLS (2019a, 2019b), OSHA analysis.

The unit cost analysis for each provision draws on the labor rates presented above in Table 7 to monetize labor burden estimates for the various potential provisions, as described in the following sections. Note that for the cost analysis of any regulation, the agency uses averages as the appropriate measures, including the estimates for labor rates and labor burdens (hours), for calculating total costs. Of course, individual facilities will have their own individual characteristics; however, what is important for total costs is whether on average the estimates are reasonable. As with all aspects of this analysis, the agency encourages comment and input from SERs on the accuracy of the estimates in this PIRFA, including suggestions of any data and datasets that will better inform the agency's analysis.

2.2 Workplace Violence Prevention Program (WVPP)

Paragraph (c) of the regulatory framework, Workplace Violence Prevention Program (WVPP), requires employers to develop, implement, and maintain a written WVPP. The WVPP contains several elements for which OSHA estimates one-time and subsequent annual review labor burdens, as applicable. OSHA then incorporates labor rates to estimate per-facility costs of compliance for paragraph (c).

Requirements provided in paragraph (c) of the regulatory framework include facilitating communication regarding the implementation of the WVPP; ensuring active involvement of employees and their representatives in developing, implementing, and reviewing the WVPP; and establishing requirements for contractors, vendors, staffing agencies, and licensed independent practitioners to adhere to the host employer's WVPP (paragraph (c)(2)(i) – (vi)). These elements together will be called "WVPP background."

Paragraph (c)(2)(ii) of the regulatory framework requires establishing effective policies and procedures, pursuant to paragraph (e), control measures, including:

- Workplace violence incident response procedures, including the appropriate use of restraints in accordance with state and local law (paragraph (e)(1)(ii)(D)); and,
- The evaluation of each new and returning patient/client/resident, including procedures for effective communication to staff of a patient/client/resident's history or potential for violence (paragraph (e)(1)(iv)).

Paragraph (c)(2)(iii) of the regulatory framework requires establishing effective policies and procedures, pursuant to paragraph (g), violent incident investigation and recordkeeping, including:

- Violent incident recordkeeping, including written procedures for employees to report a violent incident, threat, or other WPV hazards (paragraph (g)(1)(i)); and,
- Violent incident investigation, including procedures to investigate the circumstances surrounding each WPV incident (paragraph (g)(2)).

For this PIRFA, OSHA estimated the labor burden for each of the above activities, by NAICS industry, facility size, and ownership (facility size varies by ownership). Labor burdens for each activity and facility category were estimated using a combination of direct patient/client/resident care and contact employment data, and best professional judgment with input from agency technical staff and subject experts.

2.2.1 WVPP Background Development

OSHA estimated a labor burden requirement for WVPP background elements, paragraphs (c)(2)(i) and (c)(2)(iv)—(vii), for large facilities, as shown in Table 9. For example, for the initial development of these elements of the WVPP, OSHA estimated that large general and psychiatric hospitals will require a total of 40 hours of labor.

Table 9. Labor Burden Assumptions for Development of WVPP Background, under Paragraph (c)(2)(i)—(vi) – Large Facilities

NAICS Description	NAICS	Large Facilities (hours)		
		Managers	Employees	Total
General Medical and Surgical Hospitals (Other Hospitals, excluding Behavioral)	622110	30	10	40
Psychiatric and Substance Abuse Hospitals (Behavioral Health)	622210	30	10	40
Nursing Care Facilities (Residential Care)	623110	20	8	28
Residential Intellectual and Developmental Disability Facilities (Behavioral Health)	623210	12	6	18

Source: OSHA, 2023.

Next, OSHA estimated the labor burden for large facilities in the remaining NAICS codes by scaling these labor burden estimates based on facilities' relative sizes. For this analysis, the size of facilities, by NAICS industry, was measured by the number of direct patient/client/resident care and contact (PCCC) employees per facility (see Table 10). This metric for facility size was used as a proxy for estimating the cost of all of the elements (facility physical size, patient mix, etc.) that employers will need to address in the WVPP.

Then, because the affected NAICS across healthcare settings have a unique "base" NAICS industry against which to adjust in accordance with the number of PCCC employees, OSHA scaled affected employment in relation to the "base" NAICS industry. For example, the affected NAICS in the Other Hospital setting were based on the General Medical and Surgical Hospital labor burden and size. Large, for-profit General Medical and Surgical Hospitals have an average of 522 PCCC employees while large Specialty Hospitals have 125. The derived estimate of total hours for WVPP background development for large Specialty Hospitals is 9.5 hours ((125/522 =

24%) x 40 hours (estimated number of labor hours for large general and psychiatric hospitals to develop the WVPP) = 9.5 hours.) Similarly, OSHA scaled other NAICS in the Behavioral Health setting based on the Residential Intellectual and Developmental Disability Facilities labor burden and size, and OSHA scaled all other NAICS based on the Nursing Care Facility profile.

Table 10. Number of Direct Patient/Client/Resident Care or Contact Employees per Establishment

NAICS	NAICS Description	Patient/Client/Resident Care/Contact Employees (PCCC) per Establishment		
		Large	Small	Very Small
621112	Offices of Physicians, Mental Health Specialists	17	3	2
621330	Offices of Mental Health Practitioners (except Physicians)	37	4	2
621420	Outpatient Mental Health and Substance Abuse Centers	26	14	4
621493	Freestanding Ambulatory Surgical and Emergency Centers	19	10	5
621610	Home Health Care Services	73	24	5
621910	Ambulance Services	36	23	6
622110	General Medical and Surgical Hospitals	860	136	3
622210	Psychiatric and Substance Abuse Hospitals	281	132	4
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	187	79	2
623110	Nursing Care Facilities (Skilled Nursing Facilities)	97	71	4
623210	Residential Intellectual and Developmental Disability Facilities	16	14	5
623220	Residential Mental Health and Substance Abuse Facilities	34	17	5
623311	Continuing Care Retirement Communities	108	51	5
623312	Assisted Living Facilities for the Elderly	41	12	4
623990	Other Residential Care Facilities	26	14	5
624110	Child and Youth Services	30	11	5
624120	Services for the Elderly and Persons with Disabilities	89	23	4
624190	Other Individual and Family Services	34	10	4
624210	Community Food Services	7	4	4
624221	Temporary Shelters	-	10	4
624229	Other Community Housing Services	7	6	3
624230	Emergency and Other Relief Services	22	4	4
624310	Vocational Rehabilitation Services	32	16	3
	Firefighter-EMTs	166	23	10

Source: OSHA, 2023.
NA = no establishments

For the other facility sizes, SBA-defined small and very small, OSHA estimated the labor burden for each NAICS industry based on the relative size to large facilities in the specific NAICS. In addition, all labor estimates for NAICS industries in the Home Healthcare and Emergency Responder settings were assigned a 50 percent reduction in their initial estimates to account for the lack of a physical facility for these entities.

2.2.2 Policy and Procedure Development

OSHA analyzed costs for two other elements of the WVPP. OSHA estimated the labor burden for development of the policies and procedures in paragraphs (e) Control measures and (g)

Violent incident investigation and recordkeeping of the draft regulatory framework, which are required by paragraphs (c)(2)(ii) and (c)(2)(iii).

OSHA estimates that creating standard operating procedures for the development and implementation of control measures required by paragraph (c)(2)(ii) is equal to the number of hours for the WVPP background elements of (c) described above. Based on OSHA's professional judgement and consultations with subject matter experts (Abt, 2020), the agency estimates that the development of standard operating procedures for incident investigation and recordkeeping required by paragraph (c)(2)(iii) is equal to half of this same WVPP background development burden.

2.2.3 WVPP Review

Paragraph (c)(3) of the regulatory framework requires employers to review and update the WVPP at least annually and whenever necessary to reflect changes in the workplace that indicate a need to revise policies. The review includes evaluation of all data recorded in the violence incident log and incident investigations in addition to any other records and information pertaining to the implementation and effectiveness of the WVPP. OSHA assumes that the burden for this activity is equal to half of the initial WVPP background burden.

The development and implementation of the WVPP under paragraph (c) will be supported by supervisor/manager employees as well as direct patient/client care and contact employees. OSHA allocated a portion of the estimated labor burdens to these labor categories, with twice the share of the burden assigned to supervisors/managers versus direct patient/client/resident care and contact employees.

2.2.4 Total Per-Facility WVPP Development Burden and Cost

Table 11 summarizes the resulting facility-level labor burdens for paragraph (c) of the regulatory framework. The burden estimates in Table 11 vary based on NAICS, ownership, and size, following the approach outlined above. The table summarizes the results across ownership categories, weighted by the number of facilities in each NAICS industry by ownership. Large general and psychiatric hospitals have the highest burden, at an estimated average of 100 hours initially, and 20 hours annually for the WVPP review. OSHA assumes facilities have an initial minimum of one-hour of labor, where the size-scaling approach otherwise produces an estimate below one hour in total burden.

Table 6. Total Per-Facility Labor Burden for Paragraph (c), labor hours (all ownerships)

NAICS	NAICS Description	Large		Small		Very Small	
		One-Time	Annual	One-Time	Annual	One-Time	Annual
621112	Offices of Physicians, Mental Health Specialists	14.4	2.9	11.4	2.3	7.9	1.6
621330	Offices of Mental Health Practitioners (except Physicians)	41.7	8.3	14.5	2.9	7.2	1.4
621420	Outpatient Mental Health and Substance Abuse Centers	67.6	13.5	37.9	7.6	11.5	2.3
621493	Freestanding Ambulatory Surgical and Emergency Centers	3.4	0.7	1.9	0.4	1.0	0.2
621610	Home Health Care Services	26.7	5.3	9.0	1.8	1.8	0.4
621910	Ambulance Services	12.6	2.5	6.6	1.3	2.2	0.4
622110	General Medical and Surgical Hospitals	100.0	20.0	17.3	3.5	1.0	0.1
622210	Psychiatric and Substance Abuse Hospitals	100.0	20.0	47.1	9.4	1.5	0.3

NAICS	NAICS Description	Large		Small		Very Small	
		One-Time	Annual	One-Time	Annual	One-Time	Annual
622310	Specialty Hospitals (excl. Psychiatric and Substance Abuse)	25.2	5.0	11.3	2.3	1.0	0.1
623110	Nursing Care Facilities (Skilled Nursing Facilities)	70.0	14.0	51.3	10.3	3.1	0.6
623210	Residential Intellectual and Developmental Disability	45.0	9.0	40.4	8.1	15.0	3.0
623220	Residential Mental Health and Substance Abuse Facilities	93.2	18.6	48.9	9.8	13.1	2.6
623311	Continuing Care Retirement Communities	70.1	14.0	33.0	6.6	3.8	0.8
623312	Assisted Living Facilities for the Elderly	28.9	5.8	9.0	1.8	3.1	0.6
623990	Other Residential Care Facilities	16.0	3.2	8.6	1.7	3.1	0.6
624110	Child and Youth Services	18.3	3.7	6.9	1.4	3.0	0.6
624120	Services for the Elderly and Persons with Disabilities	30.8	6.2	8.1	1.6	1.4	0.3
624190	Other Individual and Family Services	20.8	4.2	5.9	1.2	2.6	0.5
624210	Community Food Services	4.4	0.9	2.4	0.5	2.6	0.5
624221	Temporary Shelters	NA	NA	5.8	1.2	2.3	0.5
624229	Other Community Housing Services	1.7	0.3	3.7	0.7	1.8	0.4
624230	Emergency and Other Relief Services	12.9	2.6	2.5	0.5	2.4	0.5
624310	Vocational Rehabilitation Services	16.8	3.4	9.7	1.9	1.9	0.4
	Firefighter-EMTs	12.2	2.4	2.0	0.4	1.0	0.2

Source: OSHA, 2023.
NA = no establishments

Labor burdens were monetized using the corresponding labor rates for management and direct patient/client/resident care and contact employees per Table 7 above. Table 12 presents OSHA's estimates of average per-facility compliance costs for paragraph (c) of the regulatory framework, which includes both one-time and annual review costs.

Table 12. Total Per-Facility Cost for Paragraph (c), $2019 (all ownerships)

NAICS	NAICS Description	Large		Small		Very Small	
		One-Time	Annual	One-Time	Annual	One-Time	Annual
621112	Offices of Physicians, Mental Health Specialists	$1,283	$257	$1,017	$203	$702	$140
621330	Offices of Mental Health Practitioners	$3,173	$635	$1,106	$221	$544	$109
621420	Outpatient Mental Health and Substance Abuse	$4,319	$864	$2,424	$485	$732	$146
621493	Freestanding Ambulatory Surgical and Emergency	$247	$49	$137	$27	$64	$13
621610	Home Health Care Services	$1,704	$341	$572	$114	$117	$23
621910	Ambulance Services	$790	$158	$417	$83	$136	$27
622110	General Medical and Surgical Hospitals	$8,494	$1,699	$1,469	$294	$27	$5
622210	Psychiatric and Substance Abuse Hospitals	$7,520	$1,504	$3,539	$708	$116	$23
622310	Specialty Hospitals (excl. Psychiatric and Substance)	$2,170	$434	$969	$194	$30	$6
623110	Nursing Care Facilities (Skilled Nursing Facilities)	$4,305	$861	$3,152	$630	$188	$38
623210	Residential Intellectual and Developmental Disability	$1,574	$315	$1,414	$283	$525	$105
623220	Residential Mental Health and Substance Abuse	$4,664	$933	$2,447	$489	$656	$131
623311	Continuing Care Retirement Communities	$3,506	$701	$1,650	$330	$189	$38

NAICS	NAICS Description	Large		Small		Very Small	
		One-Time	Annual	One-Time	Annual	One-Time	Annual
623312	Assisted Living Facilities for the Elderly	$1,446	$289	$450	$90	$154	$31
623990	Other Residential Care Facilities	$707	$141	$380	$76	$139	$28
624110	Child and Youth Services	$828	$166	$314	$63	$135	$27
624120	Services for the Elderly and Persons with Disabilities	$1,250	$250	$327	$65	$59	$12
624190	Other Individual and Family Services	$944	$189	$268	$54	$116	$23
624210	Community Food Services	$220	$44	$123	$25	$132	$26
624221	Temporary Shelters	NA	NA	$290	$58	$114	$23
624229	Other Community Housing Services	$86	$17	$188	$38	$92	$18
624230	Emergency and Other Relief Services	$653	$131	$126	$25	$120	$24
624310	Vocational Rehabilitation Services	$794	$159	$460	$92	$91	$18
	Firefighter-EMTs	$785	$157	$131	$26	$54	$11

Source: OSHA, 2023.
NA = no establishments

Table 13 presents, by facility size, labor burden and cost per-facility aggregated across NAICS industries within each healthcare setting.

Table 7. Total Per-Facility Cost for Paragraph (c), by Setting, ($2019, all ownerships)

Healthcare Setting and Size	WVPP Development Labor Burden per Facility		WVPP Development Cost per Facility	
	One-Time	Annual Recurring	One-Time	Annual Recurring
Behavioral Health				
Large	55.2	11.0	$2,520	$504
Small	26.8	5.4	$1,464	$293
Very Small	8.6	1.7	$601	$120
Other Hospitals (excluding BH)				
Large	51.2	10.2	$4,336	$867
Small	6.0	1.2	$492	$98
Very Small	1.0	0.2	$63	$13
Residential Care Facilities				
Large	53.6	10.7	$3,084	$617
Small	23.7	4.7	$1,343	$269
Very Small	3.1	0.6	$160	$32
Social Assistance				
Large	17.3	3.5	$800	$160
Small	6.0	1.2	$278	$56
Very Small	2.5	0.5	$118	$24
Home Healthcare Services				
Large	28.2	5.6	$1,542	$308
Small	8.5	1.7	$438	$88

Healthcare Setting and Size	WVPP Development Labor Burden per Facility		WVPP Development Cost per Facility	
	One-Time	Annual Recurring	One-Time	Annual Recurring
Very Small	1.6	0.3	$85	$17
Emergency Responders				
Large	12.5	2.5	$789	$158
Small	4.6	0.9	$287	$57
Very Small	1.7	0.3	$106	$21

Source: OSHA, 2023.

2.3 Workplace Violence Hazard Assessment

Paragraph (d) of the regulatory framework, Workplace Violence Hazard Assessment, specifies requirements for initial establishment-wide and high-risk area hazard assessments, including documenting the assessment, under paragraphs (d)(1)(ii) – (vi). Paragraph (d)(1)(iii) requires a review of all WPV incidents in the previous three years. Paragraph (d)(3) requires employers to perform a re-assessment pursuant to (d)(1) annually. In addition, paragraph (d)(4) requires employers with employees in fixed-facility sites to conduct additional hazard assessments in response to workplace violence incidents, as specified in paragraph (g)(3).

Paragraph (d)(1)(vi) requires a hazard assessment for high-risk service areas. These high-risk areas include emergency rooms/emergency admissions/triage areas, psychiatric care areas, behavioral health care areas, substance abuse treatment areas, home healthcare, social assistance, emergency medical services, and other areas deemed to be of high-risk for violence by the employer.

The regulatory framework also specifies that paragraph (d) *does not* apply to employers in the home healthcare or home-based social assistance, emergency medical services employers, or staffing agencies. These employers do not operate fixed-facility sites of care, and are instead subject to an alternative set of hazard assessment requirements specified in Table E-1 and Table E-2 of the regulatory framework. Based on these specifications, all employers in these industries are required to perform an abbreviated initial general hazard assessment and a three-year review of previous WPV incidents. In addition, these employers are not required to perform the subsequent high-risk area hazard assessment, under paragraph (d)(1)(vi) or the incident-related hazard assessments under paragraph (d)(4). For the purposes of SBREFA costing, behavioral health facilities have been assumed to not perform incident-related hazard assessments under (d)(4)(i) since the entirety of the facility is designated as high-risk, and such assessments are only required for incidents that occur *outside* of previously designated high-risk areas.

To summarize, there are four hazard assessment requirements for which OSHA estimates unit costs:

1. Historical three-year incident review under (d)(1)(iii)
2. Establishment-wide assessment under (d)(1)(ii) – (iv)
3. High-risk service area assessment under (d)(1)(vi)
4. Additional hazard assessments under (d)(4)

All four components are performed annually.

2.3.1 WPV Incident Review

Under paragraph (d)(1)(iii), the employer must review all workplace violence incidents within the previous three years, regardless of whether an employee sustained an injury. OSHA estimated the annual cost per facility of this provision by starting with the average number of WPV incidents per facility, per year, by NAICS, ownership, and size, based on OSHA's incident analysis, described in Appendix C. These incidents include all four incident types in the analysis: lost-work injuries, other recordable (OSHA 300 log) injuries, non-recordable injuries, and threats. Table 14 summarizes the average number of incidents per facility per year, across all ownership categories.[19]

Table 8. Average WPV Incidents per Facility, per Year, all Incident Types, all Ownerships

NAICS	NAICS Description	Large	Small	Very Small
621112	Offices of Physicians, Mental Health Specialists	0.2	0.00*	0.00*
621330	Offices of Mental Health Practitioners	0.4	0.02	0.01
621420	Outpatient Mental Health and Substance Abuse	0.4	0.16	0.04
621493	Freestanding Ambulatory Surgical and Emergency	0.2	0.12	0.05
621610	Home Health Care Services	0.3	0.10	0.02
621910	Ambulance Services	0.3	0.17	0.05
622110	General Medical and Surgical Hospitals	36.9	4.8	0.1
622210	Psychiatric and Substance Abuse Hospitals	164.0	31.2	1.7
622310	Specialty Hospitals (excl. Psychiatric and Substance)	16.2	2.4	0.1
623110	Nursing Care Facilities (Skilled Nursing Facilities)	2.6	1.6	0.1
623210	Residential Intellectual and Developmental Disability	3.6	1.1	0.8
623220	Residential Mental Health and Substance Abuse	4.9	1.6	0.5
623311	Continuing Care Retirement Communities	2.0	0.8	0.1
623312	Assisted Living Facilities for the Elderly	0.7	0.2	0.1
623990	Other Residential Care Facilities	14.6	2.2	1.2
624110	Child and Youth Services	5.7	0.6	0.4
624120	Services for the Elderly and Persons with Disabilities	1.6	0.3	0.1
624190	Other Individual and Family Services	1.4	0.1	0.1
624210	Community Food Services	0.1	0.1	0.0
624221	Temporary Shelters	NA	0.18	0.07
624229	Other Community Housing Services	0.3	0.2	0.05
624230	Emergency and Other Relief Services	0.4	0.05	0.03
624310	Vocational Rehabilitation Services	1.8	0.6	0.14

[19] To correct for underreporting of recordable lost-workday incidents, based on professional judgment, OSHA estimated that *recorded* lost workday incidents represent 50 percent of all potentially recordable lost-workday incidents, including unreported incidents. This adjustment increases incidents by eighteen percent ((reported incidents / 0.50) = 2.0 * reported incidents). Based on this adjustment, the incidence rates, covered employees, and the FTE adjustment (see Appendix C), OSHA estimated the resulting number of lost-workday WPV incidents, by NAICS, ownership, and facility size, shown by size and setting in Table C-6.

NAICS	NAICS Description	Large	Small	Very Small
Firefighter-EMTs		1.5	0.15	0.08

Source: See Appendix C
NA = no establishments;
* = appears as zero due to rounding

Next, OSHA multiplied the quantity of annual incidents by three as an estimate for the three-year lookback that the review requires, and assigned a burden of 10 minutes per incident for the review. Table 15 presents OSHA's estimates of per-facility compliance costs for the three-year incident review under paragraph (d)(1)(iii) of the regulatory framework. This review, in future years, will be a mix of incidents previously reviewed as well as new incidents that have been recorded. These costs recur annually pursuant to paragraph (d)(3) where the prior three (3) years' worth of incident records are reviewed each year. The burden was monetized using supervisor/manager wages. OSHA invites comments by SERs on the unit cost estimates presented in this PIRFA for WPV incident review.

Table 9. WPV Incident Review Burden and Cost per Facility, First Year, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621112	Offices of Physicians, Mental Health Specialists	0.1	$9	0.0	$0.2	0.0	$0.1
621330	Offices of Mental Health Practitioners	0.2	$17	0.0	$0.9	0.0	$0.5
621420	Outpatient Mental Health and Substance Abuse	0.2	$13	0.1	$5.9	0.0	$1.5
621493	Freestanding Ambulatory Surgical and Emergency	0.1	$9	0.1	$4.7	0.0	$2.2
621610	Home Health Care Services	0.1	$10	0.0	$3.5	0.0	$0.6
621910	Ambulance Services	0.1	$11	0.1	$6.7	0.0	$1.9
622110	General Medical and Surgical Hospitals	18.5	$1,765	2.4	$229.1	0.0	$3.9
622210	Psychiatric and Substance Abuse Hospitals	82.0	$7,003	15.6	$1,333.5	0.9	$72.6
622310	Specialty Hospitals (excl. Psychiatric and Substance)	8.1	$796	1.2	$115.5	0.1	$5.8
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1.3	$95	0.8	$60.4	0.0	$3.4
623210	Residential Intellectual and Developmental Disability	1.8	$74	0.6	$22.9	0.4	$16.8
623220	Residential Mental Health and Substance Abuse	2.4	$146	0.8	$47.1	0.3	$16.3
623311	Continuing Care Retirement Communities	1.0	$59	0.4	$25.3	0.0	$2.7
623312	Assisted Living Facilities for the Elderly	0.4	$22	0.1	$6.3	0.0	$2.2
623990	Other Residential Care Facilities	7.3	$375	1.1	$57.2	0.6	$31.4
624110	Child and Youth Services	2.8	$151	0.3	$15.2	0.2	$10.4
624120	Services for the Elderly and Persons with Disabilities	0.8	$38	0.2	$7.9	0.0	$1.5
624190	Other Individual and Family Services	0.7	$38	0.1	$3.0	0.0	$1.9
624210	Community Food Services	0.1	$4	0.0	$2.4	0.0	$1.4
624221	Temporary Shelters	0.0	0	0.1	$7.6	0.0	$3.0
624229	Other Community Housing Services	0.1	$8	0.1	$4.9	0.0	$2.3
624230	Emergency and Other Relief Services	0.2	$12	0.0	$2.3	0.0	$1.2
624310	Vocational Rehabilitation Services	0.9	$51	0.3	$18.2	0.1	$3.5
	Firefighter-EMTs	0.8	$58	0.1	$5.9	0.0	$3.0

Source: OSHA, 2023.
NA = no establishments

2.3.2 Establishment-Wide Hazard Assessment

Each employer must conduct an assessment to identify environmental and organizational workplace violence risk factors. This includes an assessment of the level of crime in the surrounding community where services are being rendered, per (d)(1)(iv).

OSHA estimated the labor burden per facility as a function of facility size, where for hospitals and nursing homes, facility size was measured by the total number of beds for a given facility. Here, because the assessment was more directly based on physical characteristics of the facility, the agency used total beds as a proxy where practicable versus using the number of PCCC employees as a proxy (see above, WVPP development). OSHA obtained an estimate of the average number of beds per hospital (NAICS 622110), for all reporting hospitals, and the average number of beds per psychiatric hospital (NAICS 622210), from the American Hospital Association's (AHA) 2019 Hospital Statistics Survey (AHA 2019). For nursing homes (NAICS 623110), OSHA obtained an estimate of the average number of beds from the National Center for Health Statistics (CDC, 2019).

Next, to allocate beds per facility by facility size, OSHA applied the estimates from the industry profile for the total number of employees per facility in the three affected NAICS codes, for the overall average facility by industry and by facility size (large, small, very small).[20] Because the assessment was facility wide, in the agency's estimation, total employees (versus PCCC employees) was the better proxy. OSHA then estimated the average number of beds per facility by size – large, small, and very small – for the three affected industries based on ratio of employment in these size categories to the overall average.

Table 16 summarizes the estimated number of beds per facility for the three affected industries, as well as average employees per facility. These data for beds and facilities were used as the inputs in subsequent analyses specifying facility size for the other affected NAICS industries.

For the remaining affected industries, the facility-wide assessment burden is estimated based on their employment size using the number of patient care and contact employees per establishment (see Table 9). In this case, the agency scales by size using the number of PCCC employees, rather than total employees, since this subset of employees drives the costs associated with the hazard assessment requirements. Specifically, other industries in the Other Hospital setting are estimated based on employment size relative to the hospitals inputs (622110); other industries in the behavioral health setting are estimated relative to the psychiatric hospital inputs (622210); and all other industries are estimated relative to the nursing home inputs (623110). This results in an estimate of the number of beds or bed-equivalents for each NAICS code, by facility size (large, small, and very small).

[20] "See OSHA, 2023 [Excel workbook], tabs "Profile_Private" and "Profile_Government.""

Table 10. Average Beds per Facility, all Ownerships

Facility Type and Size	Beds per Facility	Employees per Facility
General Hospital (NAICS 622110)	150	931
Large	196	1216
Small	31	192
Very Small	1	3
Psychiatric Hospital (NAICS 622210)	60	98
Large	70	115
Small	51	84
Very Small	3	4
Nursing Home (NAICS 623110)	135	291
Large	166	359
Small	78	169
Very Small	2	4

Source: OSHA, 2023, based on AHA (2019), CDC (2019).

Lastly, OSHA specifies the level of effort associated with the facility-wide assessment in terms of a minutes-per-bed measure: 20 minutes per bed (or bed-equivalent). OSHA recognizes that the assessment itself is not strictly limited to beds, but the measure is used as a proxy to capture relevant variation in facility size, similar to several other measures. Labor for the home healthcare and emergency medical response industries is further reduced by 50 percent due to the absence of a fixed physical worksite. Based on the assumption that staff in management positions, broadly defined, would be mainly involved in facilitating and carrying-out assessments (e.g. working with/arranging inspections/hiring consultants to conduct the assessments), OSHA calculated the dollar value of labor by assuming a mix of management labor and employee labor, with 75 percent allocated to management.

Table 17 summarizes facility-level labor burdens and costs for the facility-wide hazard assessment. These assessments recur annually pursuant to paragraph (d)(3), but OSHA assumes that the level of effort and associated costs is reduced by half following the first-year assessment.

Table 11. Facility-Wide Hazard Assessment Burden and Cost per Facility, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621112	Offices of Physicians, Mental Health Specialists	9	$776	1	$62	0.4	$32
621330	Offices of Mental Health Practitioners	10	$803	1	$70	0.3	$27
621420	Outpatient Mental Health and Substance Abuse	5	$340	3	$168	0.6	$41
621493	Freestanding Ambulatory Surgical and Emergency	2	$161	1	$92	0.6	$48
621610	Home Health Care Services	9	$583	3	$194	0.5	$35
621910	Ambulance Services	4	$271	2	$143	0.6	$41
622110	General Medical and Surgical Hospitals	65	$5,542	10	$874	0.3	$28

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
622210	Psychiatric and Substance Abuse Hospitals	55	$4,168	26	$1,962	0.7	$50
622310	Specialty Hospitals (excl. Psychiatric and Substance)	16	$1,415	8	$654	0.3	$25
623110	Nursing Care Facilities (Skilled Nursing Facilities)	23	$1,471	17	$1,074	0.9	$56
623210	Residential Intellectual and Developmental Disability	5	$184	3	$97	1.1	$41
623220	Residential Mental Health and Substance Abuse	7	$393	3	$168	0.8	$42
623311	Continuing Care Retirement Communities	23	$1,199	11	$559	1.1	$56
623312	Assisted Living Facilities for the Elderly	10	$495	3	$153	0.9	$46
623990	Other Residential Care Facilities	5	$241	3	$128	0.9	$40
624110	Child and Youth Services	6	$283	2	$106	0.8	$38
624120	Services for the Elderly and Persons with Disabilities	10	$426	3	$111	0.4	$17
624190	Other Individual and Family Services	7	$322	2	$91	0.7	$33
624210	Community Food Services	1	$75	1	$42	0.7	$37
624221	Temporary Shelters	NA	NA	2	$98	0.6	$32
624229	Other Community Housing Services	1	$29	1	$64	0.5	$26
624230	Emergency and Other Relief Services	4	$223	1	$43	0.7	$34
624310	Vocational Rehabilitation Services	6	$271	3	$157	0.6	$27
	Firefighter-EMTs	7	$422	3	$181	1.0	$64

Source: OSHA, 2023.
NA = no establishments

2.3.3 High-Risk Area Hazard Assessments

In addition to the hazards and risk factors in paragraph (d)(1)(v), the employer must also separately assess all high-risk service areas under paragraph (d)(1)(vi). This assessment should consider a broad set of risk factors related to access, communication, illumination, and other physical environment, patient/client/resident-related, and employer-identified organizational risks.

OSHA estimated the labor burden for the high-risk service area hazard assessment using the same general approach as the facility-wide hazard assessment, with the following modifications:

- OSHA estimated that the high-risk assessment labor burden is equal to 20 percent of the facility-wide burden. This estimate is intended to reflect that high-risk service areas subject to the additional inspection in many cases comprise a relatively small proportion of the overall facility.[21] For affected employers included in the behavioral health setting,

[21] For example, data from National Mental Health Services Survey, 2018, indicate that there are 34,367 inpatient beds in psychiatric units within general hospitals, and the AHA survey (2019) shows a total of 893,019 beds in general hospitals overall (both surveys exclude Federal facilities). These results suggest that about 3.8 percent of general hospital beds are relatively high-risk and thus are associated with an average high-risk-assessment burden that is lower than the facility wide assessment burden. Psychiatric care areas are analyzed in this example for illustrative purposes. As discussed earlier in this PIRFA, high-risk areas profiled for OSHA's cost model include emergency rooms/emergency admissions/triage areas, psychiatric care areas, behavioral health care areas,

however, the agency assumed that the entire facility is comprised of high-risk service areas; and,

- Home healthcare and home-based social assistance, and emergency responders are not subject to this requirement and therefore incur no cost.

Table 18 summarizes facility-level labor burden and cost for the high-risk service area hazard assessment. These assessments recur annually pursuant to paragraph (d)(3), but OSHA assumes that the level of effort and associated costs is reduced by half following the first year assessment.

Table 12. High-Risk Service Area Hazard Assessment Burden and Cost per Facility, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621112	Offices of Physicians, Mental Health Specialists	8.68	$776	0.70	$62	0.36	$32
621330	Offices of Mental Health Practitioners	10.22	$803	0.88	$70	0.34	$27
621420	Outpatient Mental Health and Substance Abuse	5.09	$340	2.52	$168	0.62	$41
621493	Freestanding Ambulatory Surgical and Emergency	0.44	$32	0.25	$18	0.13	$10
622110	General Medical and Surgical Hospitals	13.05	$1,108	2.06	$175	0.07	$6
622210	Psychiatric and Substance Abuse Hospitals	55.43	$4,168	26.09	$1,962	0.67	$50
622310	Specialty Hospitals (excl. Psychiatric and Substance)	3.29	$283	1.52	$131	0.06	$5
623110	Nursing Care Facilities (Skilled Nursing Facilities)	10.51	$662	7.67	$483	0.40	$25
623210	Residential Intellectual and Developmental Disability	5.04	$184	2.66	$97	1.12	$41
623220	Residential Mental Health and Substance Abuse	7.48	$393	3.19	$168	0.81	$42
623311	Continuing Care Retirement Communities	10.53	$540	4.91	$252	0.49	$25
623312	Assisted Living Facilities for the Elderly	4.34	$223	1.34	$69	0.40	$21
623990	Other Residential Care Facilities	2.40	$108	1.28	$58	0.40	$18
624110	Child and Youth Services	1.22	$57	0.46	$21	0.17	$8
624190	Other Individual and Family Services	1.39	$64	0.39	$18	0.14	$7
624210	Community Food Services	0.29	$15	0.16	$8	0.14	$7
624221	Temporary Shelters	-	NA	0.38	$20	0.12	$6
624229	Other Community Housing Services	0.11	$6	0.25	$13	0.10	$5
624230	Emergency and Other Relief Services	0.86	$45	0.17	$9	0.13	$7
624310	Vocational Rehabilitation Services	1.12	$54	0.65	$31	0.11	$5

Source: OSHA, 2023.
NA = no establishments

2.3.4 Additional Hazard Assessments

Under paragraph (d)(4), each employer must conduct additional hazard assessments in response to workplace violence incidents as specified in paragraph (g)(3). Following a workplace violence

substance abuse treatment areas, home healthcare, social assistance, emergency medical services, and other areas deemed to be of high-risk for violence by the employer.

incident in a service area or activity not previously identified as high-risk, the employer must assess the service area at issue as well as the job functions or activities that may have placed employees at increased risk for workplace violence. The area where the incident occurred could subsequently be designated as high-risk based on an assessment consistent with paragraph (d)(1)(v), and may therefore result in the need for additional engineering controls, consistent with paragraphs (e)(2) and (e)(3). For purposes of SBREFA costing, behavioral health facilities have been assumed to not perform incident-related hazard assessments under (d)(4) since the entirety of the facility is designated as high-risk, and such assessments are only required for incidents that occur outside of previously designated high-risk areas.

OSHA estimated the burden associated with these incident-related assessments based on data from OSHA incident analysis (Appendix C). Applying professional judgment, OSHA estimated that 5 percent of WPV incidents annually occur outside of previously designated high-risk areas and therefore would be subject to the assessment requirement. OSHA estimated that the per-incident assessment will require two hours of manager labor for a lost-work incident resulting in day(s) away from work[22] and one hour of manager labor for all other types of incidents.

The cost for incident-related hazard assessments under (d)(4)(i) potentially includes the need for additional engineering control equipment if the incident area is newly designated as high-risk. To estimate this additional possible cost, OSHA estimated that 5 percent of the relevant incidents result in newly designated high-risk service areas (i.e., 0.25 percent of all incidents, since incidents that occur outside previous high-risk areas are already a 5 percent subset of all incidents). For this small set of incidents resulting in newly designated high-risk service areas, OSHA estimated that affected areas will require engineering control costs equal to 5 percent of total per-facility engineering control costs (engineering control costs are discussed in Section 2.4.5, below).

In contrast to OSHA's access to published data on workplace violence incidents and WPV incidence rates, the agency lacked available data indicating the nature or frequency of physical changes in the layout, design, or amenities of the workplace that could increase the risk of workplace violence ((d)(4)(ii)); or, changes in clientele or services provided that could increase the risk of workplace violence ((d)(4)(iii)). OSHA did not quantify costs associated with additional assessments required as a result of these changes when they occur. OSHA believes that such changes (e.g., services, physical layout) are relatively uncommon compared to incidence of WPV for a typical healthcare facility, and therefore OSHA is capturing the majority of potential additional assessment costs under (d)(4)(i)–(iii) by quantifying incident-related assessment costs. OSHA invites comments from SERs on this preliminary assessment of compliance costs under (d)(4).

Table 19 summarizes the per-incident cost for a single lost-work incident that occurs outside of a high-risk service area, triggering an incident-related hazard assessment for applicable NAICS industries.

Table 13. Cost per Lost-Work Incident for Incident Hazard Assessment, all Ownerships

[22] This includes days away with or without a job transfer or restriction.

NAICS	NAICS Description	Large	Small	Very Small
621493	Freestanding Ambulatory Surgical, Emergency	$88	$85	$83
622110	General Medical and Surgical Hospitals	$356	$137	$97
622310	Specialty Hospitals (excl. Psychiatric, Substance)	$151	$128	$99
623110	Nursing Care Facilities (Skilled Nursing Facilities)	$125	$108	$75
623311	Continuing Care Retirement Communities	$128	$91	$62
623312	Assisted Living Facilities for the Elderly	$80	$66	$62
623990	Other Residential Care Facilities	$64	$58	$54
624110	Child and Youth Services	$72	$59	$57
624190	Other Individual and Family Services	$79	$58	$58
624210	Community Food Services	$63	$61	$61
624221	Temporary Shelters	NA	$62	$61
624229	Other Community Housing Services	$61	$61	$61
624230	Emergency and Other Relief Services	$70	$61	$61
624310	Vocational Rehabilitation Services	$67	$64	$57

Source: OSHA, 2023.
NA = no establishments

Table 20 summarizes total per-facility burden and cost for incident-related hazard assessments, aggregated on a facility-weighted basis across all ownership categories, based on the estimated number of incidents per facility that will require a hazard assessment.

Table 20. Incident Hazard Assessment Burden and Cost per Facility, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621493	Freestanding Ambulatory Surgical, Emergency	0.01	$1.0	0.01	$0.5	0.00	$0.2
622110	General Medical and Surgical Hospitals	1.96	$697.6	0.25	$34.8	0.00	$0.4
622310	Specialty Hospitals (excl. Psychiatric, Substance)	0.88	$132.6	0.13	$16.4	0.01	$0.6
623110	Nursing Care Facilities (Skilled Nursing Facilities)	0.14	$17.5	0.09	$9.5	0.01	$0.4
623311	Continuing Care Retirement Communities	0.10	$13.4	0.04	$4.1	0.00	$0.3
623312	Assisted Living Facilities for the Elderly	0.04	$3.1	0.01	$0.7	0.00	$0.2
623990	Other Residential Care Facilities	0.79	$50.5	0.12	$7.0	0.07	$3.6
624110	Child and Youth Services	0.31	$22.2	0.03	$1.8	0.02	$1.2
624190	Other Individual and Family Services	0.08	$6.1	0.01	$0.4	0.00	$0.2
624210	Community Food Services	0.01	$0.5	0.00	$0.3	0.00	$0.2
624221	Temporary Shelters	NA	NA	0.01	$0.9	0.01	$0.3
624229	Other Community Housing Services	0.01	$0.9	0.01	$0.6	0.00	$0.3
624230	Emergency and Other Relief Services	0.02	$1.6	0.00	$0.3	0.00	$0.1
624310	Vocational Rehabilitation Services	0.10	$6.5	0.04	$2.2	0.01	$0.4

Source: OSHA, 2023.
NA = no establishments; results of 0.00 hours are due to rounding.

2.3.5 Total Per-Facility Hazard Assessment Cost

Table 21 presents OSHA's estimates of total per-facility costs to comply with paragraph (d) of the regulatory framework. In OSHA's preliminary cost model, hazard assessments recur annually, per paragraph (d)(3), although the cost model projects that 50 percent less effort will be required for assessments following the first year.

Table 14. Total Per-Facility Hazard Assessment Cost, Initial Year, by NAICS Code, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621112	Offices of Physicians, Mental Health Specialists	17.4	$1,560	1.4	$125	0.7	$65
621330	Offices of Mental Health Practitioners	20.6	$1,623	1.8	$140	0.7	$54
621420	Outpatient Mental Health and Substance Abuse	10.4	$692	5.1	$342	1.3	$84
621493	Freestanding Ambulatory Surgical, Emergency	2.7	$203	1.6	$116	0.8	$60
621610	Home Health Care Services	9.0	$594	3.0	$198	0.5	$36
621910	Ambulance Services	4.3	$281	2.8	$180	0.7	$43
622110	General Medical and Surgical Hospitals	98.7	$9,112	15.0	$1,313	0.4	$38
622210	Psychiatric and Substance Abuse Hospitals	192.9	$15,339	67.8	$5,257	2.2	$173
622310	Specialty Hospitals (excl. Psychiatric, Substance)	28.7	$2,627	10.4	$917	0.4	$37
623110	Nursing Care Facilities (Skilled Nursing Facilities)	35.3	$2,246	25.6	$1,627	1.3	$85
623210	Residential Intellectual, Developmental Disability	11.9	$442	5.9	$217	2.6	$98
623220	Residential Mental Health and Substance Abuse	17.4	$933	7.2	$382	1.9	$101
623311	Continuing Care Retirement Communities	35.0	$1,811	16.3	$841	1.6	$85
623312	Assisted Living Facilities for the Elderly	14.4	$742	4.4	$228	1.3	$69
623990	Other Residential Care Facilities	15.8	$774	5.4	$250	2.0	$93
624110	Child and Youth Services	10.5	$513	3.1	$145	1.2	$58
624120	Services for Elderly and Persons with Disabilities	11.1	$465	2.8	$119	0.4	$19
624190	Other Individual and Family Services	9.1	$431	2.4	$112	0.9	$42
624210	Community Food Services	1.8	$95	1.0	$53	0.9	$46
624221	Temporary Shelters	-	$0	2.4	$126	0.8	$42
624229	Other Community Housing Services	0.8	$44	1.6	$82	0.6	$33
624230	Emergency and Other Relief Services	5.4	$281	1.0	$54	0.8	$42
624310	Vocational Rehabilitation Services	7.7	$382	4.2	$208	0.7	$36
	Firefighter-EMT	7.3	$479	2.9	$187	1.0	$67

Source: OSHA, 2023.

Table 22 summarizes annually recurring total per-facility hazard assessment costs at the more aggregate healthcare setting level. OSHA invites public comment on the data sources and methodological assumptions underlying the agency's estimation of costs for paragraph (d) Workplace Violence Hazard Assessment.

Table 15. Total Per-Facility Hazard Assessment Cost, Initial Year, by Setting, all Ownerships

Healthcare Setting and Size	Historical Incident Review	Facility Assessment	High-Risk Assessment	Incident Assessments	Total
Behavioral Health					
Large	$445.8	$437.0	$437.0	NA	$1,319.8
Small	$14.3	$101.2	$101.2	NA	$216.7
Very Small	$2.7	$31.3	$31.3	NA	$65.2
Other Hospitals (excluding BH)					
Large	$915.6	$2,828.9	$565.8	$343.4	$4,653.7
Small	$63.8	$302.7	$60.5	$9.5	$436.6
Very Small	$2.2	$46.9	$9.4	$0.2	$58.7
Residential Care Facilities					
Large	$88.5	$1,054.4	$474.5	$15.0	$1,632.3
Small	$30.4	$456.8	$205.5	$4.4	$697.2
Very Small	$6.0	$47.5	$21.4	$0.7	$75.5
Social Assistance					
Large	$61.2	$273.0	$54.6	$8.9	$397.7
Small	$7.2	$94.5	$18.9	$0.9	$121.5
Very Small	$3.7	$33.4	$6.7	$0.4	$44.3
Home Healthcare Services					
Large	$20.5	$527.2	$0.0	$0.0	$547.6
Small	$5.9	$148.5	$0.0	$0.0	$154.4
Very Small	$1.1	$25.4	$0.0	$0.0	$26.5
Emergency Response					
Large	$22.2	$307.9	$0.0	$0.0	$330.2
Small	$6.3	$177.8	$0.0	$0.0	$184.0
Very Small	$2.3	$49.6	$0.0	$0.0	$51.8

Note: Behavioral health settings have a single high-risk area throughout a facility and hence will have no further incident-related hazard assessments, while home healthcare and emergency response are not subject to the requirement of a high-risk hazard assessment and incident-related assessment.
Source: OSHA, 2023.

2.4 Control Measures

Paragraph (e) of the regulatory framework, Control Measures, requires employers to implement workplace violence control measures to address workplace violence hazards based on the hazard assessments.
Unit costs for policies and procedures specified under paragraph (e)(1) are included as part of the unit costs for the WVPP pursuant to paragraph (c)(2)(ii), above.

2.4.1 Engineering Control Equipment and Support Staff Unit Costs

Paragraphs (e)(2), (e)(3), and (e)(4) address requirements for controls and are organized into two broad categories: (1) engineering controls and (2) work practice controls. These control requirements are aimed at eliminating or minimizing employee exposure to identified hazards, as

applicable, for a given facility. Several control requirements only apply to high-risk areas as specified in paragraphs (e)(2) and (e)(3). OSHA anticipates that a facility may need to procure specific equipment and/or services in order to achieve compliance with some of the control requirements under paragraphs (e)(1), (e)(2), (e)(3), and (e)(4). Among the specifications that will result in control costs include:

- Designing the physical layout of public areas in the workplace, including waiting rooms and hallways, such that room configuration, furniture dimensions, or other floor arrangements do not impede employee observation of activity within the facility. This requirement includes the removal of sight barriers, the provision of surveillance systems or other sight aids such as mirrors, improved illumination, and the provision of alarm systems or other effective means of communication where the physical layout prevents line of sight;
- Ensuring that employees have unobstructed access to alarms and exit doors as a means to escape violent incidents;
- Ensuring that video surveillance equipment, if any, is operable for the purpose it is intended;
- Removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons in areas where direct patient/client/resident contact/care activities are performed;
- Installing protective barriers between employees and patients/visitors in areas such as admission, triage, and nursing stations;
- Installing, implementing, and maintaining the use of an alarm system, personal panic alarms, or other effective means of emergency communication for employees with direct patient/client or resident care/contact duties;
- Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patient/client/residents are reasonably anticipated to possess unauthorized firearms or other weapons. This could include monitoring and controlling designated public entrances by use of safeguards such as metal detection devices, remote surveillance, alarm systems, or a registration process to limit access to the facility by unauthorized individuals conducted by personnel who are in an appropriately protected work station;
- Maintaining staff designated to immediately respond to workplace violence incidents. To meet this requirement, OSHA estimated the cost for the time spent for staff to respond to incidents. The cost assumes that the staff responding are already employed, and the cost is the time during which they are diverted by responding to incidents; [23]

[23] OSHA expects that compliance with the draft regulatory text would not lead to the need for additional hires. The agency invites comment from SERs on this preliminary assessment.

- Ensuring employee staffing patterns are sufficient to address workplace violence hazards in high-risk service areas; and,
- OSHA estimated unit costs for the range of control equipment and labor burden that will be needed to meet the requirements indicated above.

Table 23 presents the set of control equipment included in the analysis along with the unit cost for each type of control equipment, which in some cases vary by the size of the equipment or system. [24] In estimating the total costs for engineering controls, OSHA applied a 20 percent mark-up to the unit cost shown in Table 23 to account for installation, operation, and maintenance of each control unit.

Table 16. Engineering and Work Practice Control Equipment Unit Costs

Control Name	Unit Cost	Units
Indoor lights	$250	Per new indoor light fixture
Outdoor lights	$700	Per new outdoor light fixture
Circular or curved mirrors	$50	Per mirror
Electronic access controls		
Small	$1,000	Per system
Large	$2,000	Per system
Enclosed workstations with shatter-resistant glass	$250	Per workstation
Deep service counters	$8,000	Per counter
Opaque glass in patient rooms	$25	Per room
Separate rooms or areas for high-risk patients	$500	Per room
Two-way radios	$50	Per radio
Paging system		
Small	$900	Per system
Large	$3,900	Per system
Personal panic devices	$50	Per panic device
Weapon detector, handheld	$150	Per handheld detector
CCTV System		
Small	$1,000	Per system
Large	$8,000	Per system
Locks on doors	$225	Per lock
Note: See Appendix D for sources and details		

Source: OSHA, 2023.

2.4.2 Facility Control Equipment Requirements

OSHA's preliminary cost analysis required estimating the number of each type of control equipment that would be necessary for facilities to comply with paragraph (e) of the regulatory

[24] Among the controls listed in Table 23, OSHA has included in the cost model, controls that have become standard in the prevention or escalation of workplace violence even though not required by paragraph (e) in the regulatory framework. OSHA invites comment on this methodological assumption and on the experience of SERs in relation to the use of the controls listed in Table 23.

framework. OSHA recognizes that there is considerable uncertainty in these estimates. Facilities even within the same industry and employee size category can exhibit a high level of variability with respect to the size and layout of their physical facility and surrounding grounds as well as the particular type and cost of controls required to meet facility-specific needs. In addition, the draft rule allows for some discretion by employers in identifying high-risk areas and assessing the optimal set of controls to mitigate risks.

In addition, the rule allows for some discretion by employers in identifying high-risk areas and assessing the optimal set of controls to mitigate risks, further elevating the range of uncertainty in modeling controls. Nevertheless, OSHA judges these estimates useful in illustrating a reasonably representative combination of controls for each setting and size.

The control requirements under paragraph (e) are not mandatory for home healthcare and emergency responder facilities; these facilities are subject to the control requirements specified in Table E-1 and Table E-2 of the draft regulatory framework. The engineering controls in Tables E-1 and E-2 exclusively address communication devices – specifically two-way radios and personal panic devices – and therefore OSHA only estimated costs for these two types of controls for home healthcare and emergency response.[25] Fire fighter-EMTs are assumed to already be provided with all needed communication devices.

Table 24 summarizes OSHA's approach for estimating the number of each control required, on average, per facility.

Table 17. Methodological Assumptions Underlying Engineering and Work Practice Control Equipment Unit Costs

Control Name	Approach for Facility Equipment Estimates
	Each facility is assigned a quantity of controls equal to . . .
Two-way radios	10% of patient care and contact employees per facility
Personal panic devices	10% of patient care and contact employees per facility
Paging system	25% of patient care and contact employees per facility
Electronic access controls	25% of patient care and contact employees per facility
Enclosed workstations with shatter-resistant glass	An assumption of 2 workstations for large psychiatric hospitals, and scaling other industries and sizes based on their relative size, where size is indicated by the number of high-risk beds per facility (high-risk beds is equal to 100% of total beds for behavioral health and 20% of total beds for other settings, as described in Section 2.3.3).
Deep service counters	An assumption of 2 counters for large psychiatric hospitals, and scaling other industries and sizes based on their relative size, where size is indicated by the number of high-risk beds per facility.
Locks on doors	An assumption of 25 locks for large psychiatric hospitals, and scaling other industries and sizes based on their relative size, where size is indicated by the number of high-risk beds per facility.
CCTV System	An assumption of 1 system for large psychiatric hospitals, and scaling other industries and sizes based on their relative size, where size is indicated by the number of total beds per facility (see Table 16).
Indoor lights	An assumption of 25 lights for large psychiatric hospitals, and scaling other industries and

[25] Control costs for home healthcare and emergency responder facilities will include the costs for communication devices along with other administrative and work practice controls.

	sizes based on their relative size, where size is total beds per facility.
Outdoor lights	An assumption of 15 lights for large psychiatric hospitals, and scaling other industries and sizes based on their relative size, where size is total beds per facility.
Separate rooms or areas for high-risk patients	5% of the number of high-risk beds per facility
Opaque glass in patient rooms	10% of the number of high-risk beds per facility
Circular or curved mirrors	5% of the number of high-risk beds per facility
Weapon detector, handheld	An assumption of 1 handheld detector for large psychiatric hospitals, and scaling other industries and sizes based on total beds per facility. In addition, OSHA assumes that only a subset of facilities, by setting, will require weapon detectors. These include 100% of behavioral health, 83% of other hospitals, 69% of residential care facilities, and 34% of social assistance facilities.[1]
[1] 83% is the percentage of general hospitals with an emergency department, per AHA (2019); 69% is the percentage of residential care facilities providing mental health services, and 34% is the percentage of social assistance facilities providing mental health services (CDC, 2019).	

Source: OSHA, 2023.

Note: "Beds" here are either actual beds or "bed-equivalents" as discussed in Section 2.3.3.

The number of equipment units assigned to each facility was estimated as the number of units required beyond what facilities might otherwise have in place. For example, OSHA did not specify the total number of lights required for a hospital, but rather the number of additional lights a facility might need to comply with the rule. At the same time, OSHA recognizes that facilities may already have, to varying degrees, sufficient controls in place to address the requirements. OSHA accounts for baseline compliance with respect to these additional controls in the total cost analysis below.

2.4.3 Facility Control Equipment Costs

Per-facility costs are a function of 1) the equipment unit cost, 2) the number of units per facility, and 3) the cost for installation estimates as 20 percent of the purchase price. Some controls (enclosed workstation, weapon detector, etc.) can only be purchased in indivisible units. Average per-facility costs typically will represent a mixture of facilities who buy the control and those who purchase none. Table 25 below summarizes average total equipment costs per facility. Appendix E includes detailed tables with costs by type of equipment.

2.4.4 Incident Response Costs

In addition to control equipment, OSHA estimates the additional labor burden and cost to respond to WPV incidents per paragraph (e). OSHA bases this estimate on the estimated number of WPV incidents per facility (see Table 14) and an assumption that each incident requires on average a total of 0.75 hours of response from patient/client/resident care or contact employees (e.g., 3 people, 15 minutes each, for example). This cost applies to all facilities except for those in the home healthcare and emergency response settings, and is an annually recurring burden and cost. See Table 25 below.

2.4.5 Total Per-Facility Control Costs

Table 25 summarizes total per-facility costs under paragraph (e) of the draft regulatory framework, including total equipment costs and labor costs associated with responding to WPV incidents. In all cases, average control costs are much higher than average incident response costs. As noted above, these are costs before taking into account current compliance practices by facilities, which is discussed below.

Table 18. Total Per-Facility Control Costs and Per-Incident Response Team or Individual Responder Costs, all Ownerships ($2019)

NAICS	NAICS Description	Large		Small		Very Small	
		Equipment	Responder	Equipment	Responder	Equipment	Responder
621112	Offices of Physicians, Mental Health Specialists	$10,786	$12.04	$1,955	$0.26	$735	$0.17
621330	Offices of Mental Health Practitioners	$13,938	$16.86	$2,089	$0.89	$728	$0.48
621420	Outpatient Mental Health and Substance Abuse	$7,431	$10.71	$3,651	$4.86	$938	$1.25
621493	Freestanding Ambulatory Surgical, Emergency	$2,680	$8.32	$1,531	$4.57	$740	$2.10
621610	Home Health Care Services	$875	$0.00	$294	$0.00	$59	$0.00
621910	Ambulance Services	$427	$0.00	$273	$0.00	$77	$0.00
622110	General Medical and Surgical Hospitals	$100,439	$1,473.35	$17,005	$191.27	$393	$3.23
622210	Psychiatric and Substance Abuse Hospitals	$69,811	$5,485.06	$36,916	$1,044.43	$843	$56.88
622310	Specialty Hospitals (excl. Psychiatric, Substance)	$23,392	$604.30	$10,701	$87.68	$355	$4.42
623110	Nursing Care Facilities (Skilled Nursing Facilities)	$21,794	$61.40	$14,773	$38.97	$820	$2.20
623210	Residential Intellectual, Developmental Disability	$6,857	$62.39	$3,843	$19.24	$1,575	$14.08
623220	Residential Mental Health and Substance Abuse	$10,673	$108.40	$4,125	$34.93	$1,072	$12.09
623311	Continuing Care Retirement Communities	$22,471	$36.35	$9,897	$15.64	$1,004	$1.68
623312	Assisted Living Facilities for the Elderly	$8,938	$13.67	$2,564	$3.88	$816	$1.39
623990	Other Residential Care Facilities	$5,249	$295.81	$2,635	$45.19	$863	$24.78
624110	Child and Youth Services	$6,140	$103.70	$2,153	$10.42	$846	$7.12
624120	Services for Elderly and Persons with Disabilities	$1,082	$0.00	$279	$0.00	$51	$0.00
624190	Other Individual and Family Services	$7,049	$26.15	$1,829	$2.05	$717	$1.31
624210	Community Food Services	$1,440	$3.13	$768	$1.76	$747	$0.99
624221	Temporary Shelters	$0	$0.00	$1,282	$5.52	$690	$2.14
624229	Other Community Housing Services	$814	$5.87	$972	$3.57	$621	$1.68
624230	Emergency and Other Relief Services	$4,285	$8.92	$785	$1.70	$677	$0.85
624310	Vocational Rehabilitation Services	$5,527	$34.16	$3,035	$12.29	$540	$2.34
	Firefighter-EMTs	$0	$0.0	$0	$0.00	$0	$0.00

Source: OSHA, 2023.
NA = no establishments; Costs shown as $0 indicate no additional compliance action anticipated for the requirement.

2.5 Training

Paragraph (f) of the regulatory framework, Training, requires that employers institute a training program for employees with direct patient/client/resident contact, direct patient/client/resident care, and/or workplace violence incident response duties, along with their supervisory staff. The training program must include the following elements:

- Under paragraph (f)(1), training is required to occur initially, prior to the time of assignment, or when newly assigned to perform duties for which the training is required. In addition, affected employees are required to participate in training at least annually and in some cases more frequently if changes in the job duties or other circumstances require supplemental training;
- Pursuant to paragraphs (f)(3) and (f)(4), the initial training program must contain content that reflects the level of risk to employees and the duties that they are expected to perform. As a result, this preliminary cost analysis included separate training estimates for employees and supervisors with patient care and contact duties;
- Paragraph (f)(5) requires employees within certain occupational categories who are working in high-risk service areas to receive an intermediate level of training. The analysis therefore differentiates training estimates within occupational categories to reflect a mix of high-risk and non-high-risk service area employees; and,
- Under paragraph (f)(6), employees designated to respond to a violent incident and their supervisors must receive an advanced level of instruction with all elements listed in paragraphs (f)(3), (f)(4), and (f)(5). These employees and their supervisors must also be given advanced practical training in de-escalation, chemical and physical restraints (if applicable), and all standard operating procedures that are applicable to the response team.

OSHA's analysis of training costs accounts for all of the above requirements and specifications. Under paragraph (f)(2), all of the above training is required to be overseen or conducted by a person knowledgeable in the program's subject matter as it relates to the workplace. The analysis therefore also includes costs associated with the procurement of trainers to conduct the training of applicable employees.

2.5.1 Patient Care, Contact, and Supervisory Employee Training Costs

Employer costs to train employees under the above requirements include the labor cost for employees' time during the training. The number of employees trained annually for a given facility is based on the number of patient/client/resident care, patient/client/resident contact, and related supervisory employees. The cost for employees' time participating in the training is driven by the number of hours of training per employee and their respective wage. As noted above, the nature of the required training varies for different groups of trainees. OSHA specifically estimates trainee labor burden – the number of required hours of training per trainee– for three categories of employees:

- Non-high-risk service area patient care employees and their supervisors;
- High-risk service area patient care employees and their supervisors;[26] and

[26] Initial training for employees designated to respond to a violent incident and their supervisors, must contain an advanced level of instruction with all elements listed in (f)(3), (f)(4), and (f)(5) and all standard operating

- Patient contact employees and their supervisors.

The number of annual hours of training for each standard and intermediate trainee-category is shown below in Table 26. OSHA specifies training hours for the initial training under the draft regulatory framework, as well as hours for the subsequent annual refresher training. OSHA assumes that standard training in non-high-risk areas is 4 hours for patient care employees and 2 hours for patient contact employees, as well as their respective supervisors. High-risk service area patient care employees and their supervisors get intermediate training and receive twice the hours as those receiving standard training. The refresher training is assumed to be half of the initial training hours.

Table 19. Standard and Intermediate Training Hours, by Employee Category

Training Type	Hours-Initial	Hours-Refresher
High-Risk Patient Care Employee and Supervisor	8	4
Non-High-Risk Patient Care Employee and Supervisor	4	2
Patient Contact Employee and Supervisor	2	1

Source: OSHA, 2023.

With respect to the intermediate training for employees in high-risk service areas, OSHA estimated that 100 percent of patient care employees in behavioral health settings, 45 percent of residential care patient care employees, and 20 percent of patient care employees in other settings participate in the intermediate training. No patient contact-only employees will need to participate in the intermediate training, as specified in the rule.

The total quantity of training hours per facility, by employee type, was then monetized using wages for patient care, patient contact, and supervisor employees. In subsequent years, employees that have already been trained will take refresher training. At the same time, new employees will enter the industry annually who will need initial training. OSHA therefore estimated the cost for employee labor per-facility both initially (year one), and for subsequent years. The cost in subsequent years assumes that 35.5 percent of employees receive the initial training each year, and 64.5 percent receive the refresher training. These percentages were based on an estimated employment turnover rate of 35.5 percent for the healthcare and social assistance industry in 2018 (BLS, 2019c).

2.5.2 Trainer Costs

Training costs include the cost of trainers that provide the instruction. The cost of trainers for a facility is based on facility size in terms of the overall number of patient care, patient contact, and related supervisor employees per facility, as well as the number of trainees that can be taught by a trainer at one time (classroom size).

To estimate the cost to employers for supplying the required trainers, OSHA applied two assumptions.

procedures that are applicable to the response team, or individual responders, as applicable. OSHA therefore assumes that those responding will come from the pool of employees and supervisors with direct patient/client/resident care duties in high-risk service areas that must receive training pursuant to f(5), which encompasses training under f(3) and f(4).

- In most cases, OSHA assumes that facilities will hire outside trainers. The cost per trainer in this case is the time (labor) for the trainer to conduct the training sessions specified above. The quantity of hours required for a trainer to administer the training is based on classroom hours and an estimated class size of 20 employees, and the trainer labor burden was monetized using the training specialist wage for the NAICS code (see Table 6).[27]

- OSHA anticipates that some, particularly large, employers may comply with the training requirements by developing in-house trainers certified at a level commensurate with the standards outlined in paragraph (f) of the regulatory framework. These in-house trainers may also be assigned to respond to workplace violence. OSHA assumes that large general, specialty, and psychiatric hospitals will use this approach for procuring trainers and creating incident response teams under the regulatory framework. For this preliminary cost analysis, the agency estimated that two percent of all patient/client/resident care/contact employees in facilities affected by this requirement will receive this training in 20-employee classroom (sizes) and subsequently serve on response teams. The wage estimate for the trainer in this case was based on the direct patient/client/resident care occupation category, rather than that of the outside training specialist. OSHA has also accounted for an additional cost for each trainer, incurred by the employer, to have the employee(s) certified through intensive training.

  The unit costs of compliance for employees undergoing intensive training include an annual training course cost, as well as the cost of labor for the time spent during the certification course. Based on consultation and input from subject matter experts, OSHA estimated that in-house trainers on an incident response team will require:[28]

  - A three-day certification program at a cost of $1,750 per employee, plus 24 hours of class time for employees seeking certification as in-house trainers; and,

  - A one-day recertification program at a cost of $750 per employee, plus 8 hours of class time for current in-house trainers obtaining recertification in subsequent years. OSHA assumed that in-house trainers will be re-certified every three years through the one-day program. After the first year, OSHA assumes that employees previously designated as in-house trainers have an annual turnover rate of 18

[27] If the average number of employees being trained per establishment is below 20 in a NAICS size class, then employees per class is adjusted downwards accordingly (increasing trainer costs per employee).

[28] Unit cost estimates are based on consideration of a range of similar training programs. For example, CPI: Nonviolent Crisis Intervention Training Program offers programs such as a one-day seminar on de-escalation and prevention ($1,179 per person); a two-day classroom foundation course ($1,799); and, a four-day certification program ($3,249). The Handle With Care Behavior Management System® QBS: Quality Behavioral Solutions to Complex Behavior Problems program includes a three-day certification program at a cost of $1,250 per person, the Quality Behavioral Solutions to Complex Behavior Problems (SAFETY CARE) three-day certification costs $1,325 per person, and the MOAB (Management of Aggressive Behavior) Training Institute offers a three-day course for $1,555 per person.

percent (approximately half of the overall employee turnover rate cited above). Knowing the costs of replacing an in-house trainer, employers are likely to train staff that they believe will be there long term. Therefore, each year approximately 18 percent of in-house trainers are replaced, requiring selected staff to take the full 24-hour course; and 82 percent of in-house trainers take the re-certification every three years or about 27 percent each year.[29]

For facilities that use in-house trainers, OSHA adjusted the employee-trainee costs from Section 2.5.1 to subtract in-house trainers from the broader pool of trainees. That is, employees designated to become in-house trainers do not also need to be a participant in the training, with its associated cost.

In OSHA's cost model, other industries and employer sizes were assumed to hire outside trainers. These facilities will not incur the additional cost for developing in-house trainers nor will they have incident response teams. Outside trainer labor was monetized using trainer wages for each industry, while in-house trainers use their current occupation wage.

Using in-house trainers versus outside trainers adds a significant cost for hospitals, the one group that OSHA estimated will use this method.[30] The first-year cost for large general hospitals, for example, is $58,000 per facility, on average, with in-house trainers, versus $11,000 for outside trainers. The benefit will be that these in-house trainers could then be designated to respond to workplace violence incidents, as required by the regulatory framework, and may be able to give standard training to fellow employees.

Table 27 summarizes total training costs per employee trained, in year one and subsequent years, including both trainer- and trainee-related costs. Per-employee costs are driven by the above elements of the analysis, including differences in facility size. For example, per-employee costs are higher in the "Offices of Physicians, Mental Health Specialists" industry when compared to "Psychiatric and Substance Abuse Hospitals", even though both types of facilities are entirely high-risk. The difference on a per-employee basis in this case is mostly due to facilities in the former being very small (most are fewer than 20 employees). This size difference results in the cost of each training class, or session, being divided among a smaller number of people in the "Offices of Physicians, Mental Health Specialists" industry since they generally do not have enough employees to use the entire 20-person capacity per-class.

2.5.3 Total Per-Employee and Facility Training Costs

Table 20. Total Training Cost Per-Employee, all Ownerships ($2019)

NAICS	NAICS Description	Large Facility		Small Facility		Very Small Facility	
		First Year	Subsequent Years	First Year	Subsequent Years	First Year	Subsequent Years
621112	Offices of Physicians, Mental Health Specialists	$700	$472	$753	$503	$755	$504

[29] This is a simplifying approximation to what would be a complicated temporal sequence of the number being re-certified, which depends on the number of years between re-certification for those trainers who leave over time.

[30] As presented below in Table 33, OSHA preliminarily estimates that current compliance with the training requirements in the regulatory framework range from 50 percent to 65 percent for hospitals. The agency invites comment on that preliminary estimate.

NAICS	NAICS Description	Large Facility		Small Facility		Very Small Facility	
		First Year	Subse-quent Years	First Year	Subse-quent Years	First Year	Subse-quent Years
621330	Offices of Mental Health Practitioners	$476	$321	$544	$360	$668	$434
621420	Outpatient Mental Health and Substance Abuse	$364	$245	$372	$250	$424	$280
621493	Freestanding Ambulatory Surgical, Emergency	$272	$183	$280	$188	$312	$207
621610	Home Health Care Services	$167	$112	$167	$112	$205	$134
621910	Ambulance Services	$158	$106	$162	$108	$182	$120
622110	General Medical and Surgical Hospitals	$324	$188	$270	$182	$337	$221
622210	Psychiatric and Substance Abuse Hospitals	$418	$253	$418	$253	$489	$319
622310	Specialty Hospitals (excl. Psychiatric, Substance)	$308	$177	$256	$172	$342	$223
623110	Nursing Care Facilities (Skilled Nursing Facilities)	$192	$129	$192	$129	$234	$153
623210	Residential Intellectual, Developmental Disability	$201	$135	$206	$138	$217	$144
623220	Residential Mental Health and Substance Abuse	$255	$171	$258	$173	$298	$196
623311	Continuing Care Retirement Communities	$145	$97	$145	$97	$171	$113
623312	Assisted Living Facilities for the Elderly	$147	$98	$156	$104	$194	$126
623990	Other Residential Care Facilities	$164	$110	$169	$113	$193	$127
624110	Child and Youth Services	$134	$90	$142	$95	$152	$101
624120	Services for Elderly and Persons with Disabilities	$121	$81	$121	$81	$136	$90
624190	Other Individual and Family Services	$134	$90	$146	$97	$150	$99
624210	Community Food Services	$175	$116	$196	$129	$177	$116
624221	Temporary Shelters	NA	NA	$173	$115	$190	$125
624229	Other Community Housing Services	$175	$116	$182	$120	$200	$131
624230	Emergency and Other Relief Services	$165	$110	$198	$130	$184	$120
624310	Vocational Rehabilitation Services	$133	$89	$136	$91	$167	$109
	Firefighter-EMT	$143	$96	$141	$95	$150	$99

Source: OSHA, 2023.
NA = no establishments

Table 28 summarizes total training costs per facility, in year one and subsequent years, including both trainer- and trainee-related costs.

Table 21. Total Per-Facility Training Cost, all Ownerships ($2019)

NAICS	NAICS Description	Large Facility		Small Facility		Very Small Facility	
		First Year	Subse-quent Years	First Year	Subse-quent Years	First Year	Subse-quent Years
621112	Offices of Physicians, Mental Health Specialists	$10,708	$7,218	$2,692	$1,788	$1,970	$1,298
621330	Offices of Mental Health Practitioners	$17,435	$11,746	$2,360	$1,563	$1,289	$837
621420	Outpatient Mental Health and Substance Abuse	$9,356	$6,296	$5,119	$3,437	$1,679	$1,107
621493	Freestanding Ambulatory Surgical, Emergency	$5,110	$3,440	$2,923	$1,959	$1,473	$977
621610	Home Health Care Services	$12,169	$8,158	$4,083	$2,737	$1,017	$666
621910	Ambulance Services	$5,630	$3,778	$2,131	$1,421	$1,168	$771
622110	General Medical and Surgical Hospitals	$281,693	$163,002	$36,684	$24,702	$913	$596

NAICS	NAICS Description	Large Facility		Small Facility		Very Small Facility	
		First Year	Subse-quent Years	First Year	Subse-quent Years	First Year	Subse-quent Years
622210	Psychiatric and Substance Abuse Hospitals	$46,585	$28,236	$55,227	$33,474	$1,139	$740
622310	Specialty Hospitals (excl. Psychiatric, Substance)	$58,380	$33,664	$20,222	$13,608	$832	$540
623110	Nursing Care Facilities (Skilled Nursing Facilities)	$18,762	$12,594	$13,654	$9,165	$1,027	$672
623210	Residential Intellectual, Developmental Disability	$3,632	$2,433	$2,972	$1,988	$1,330	$876
623220	Residential Mental Health and Substance Abuse	$8,642	$5,807	$4,411	$2,960	$1,460	$961
623311	Continuing Care Retirement Communities	$15,587	$10,450	$7,327	$4,912	$921	$604
623312	Assisted Living Facilities for the Elderly	$5,719	$3,834	$1,863	$1,242	$789	$514
623990	Other Residential Care Facilities	$4,344	$2,917	$2,326	$1,557	$937	$616
624110	Child and Youth Services	$4,327	$2,904	$1,614	$1,076	$798	$524
624120	Services for Elderly and Persons with Disabilities	$10,920	$7,327	$2,813	$1,887	$655	$428
624190	Other Individual and Family Services	$5,043	$3,383	$1,392	$926	$698	$456
624210	Community Food Services	$1,271	$846	$790	$520	$774	$509
624221	Temporary Shelters	$0	$0	$1,628	$1,087	$743	$488
624229	Other Community Housing Services	$1,168	$776	$1,115	$740	$626	$409
624230	Emergency and Other Relief Services	$3,469	$2,333	$802	$528	$715	$469
624310	Vocational Rehabilitation Services	$3,698	$2,483	$2,151	$1,444	$522	$340
	Firefighter-EMT	$19,538	$13,105	$3,169	$2,126	$1,432	$952

Source: OSHA, 2023.

2.6 Violent Incident Investigation and Recordkeeping

Paragraph (g) of the regulatory framework has several requirements the employer must implement regarding violent incident reporting and maintenance of related records. The requirements costed here are organized into three categories:[31]

- **Violent incident investigation.** Paragraph (g)(2) requires that employers establish procedures to investigate the circumstances of each reported WPV incident within 24 hours of notification of the incident occurring and document the significant contributing factors, recommendations, and any corrective measures that will be taken to prevent similar incidents.
- **Violent incident log.** Paragraphs (g)(1) and (g)(4) require that employers implement and maintain a violent incident reporting system and establish and maintain records of each violent incident that occurs in the workplace. Employers are required to solicit input from the employee(s) who experienced or observed the workplace violence. The violent incident log must include key information such as, but not limited to: the nature and extent of the employee's injuries; the date, time, and location of the incident; the job titles

[31] Costs for investigation procedures specified under paragraph (g)(1) are included as part of the costs for the WVPP pursuant to paragraph (c). Incident-related hazard assessment costs specified under paragraph (g)(3) are accounted for in the costs for paragraph (d), hazard assessments.

of involved employee(s); a classification of circumstances at the time of the incident; and a classification of the person who committed the violence (e.g., patient, coworker, stranger, etc.).

- **Retention of records.** Paragraph (h) requires that employers maintain records from WVPP development, hazard assessment and control processes, and incident investigations for at least three years. In addition, training records are to be maintained for at least one year.

The labor burden and cost per facility presented here will be constant each year, assuming the same number of incidents occur each year. Hence, recurring costs for these elements will be overestimated to the extent the implementation of the regulatory framework is effective and decreases the number of WPV incidents.

2.6.1 Violent Incident Investigation Costs

Incident investigation costs are a function of the estimated number of incidents per facility, and the labor burden for investigating different types of incidents.

The number of incidents per facility per year is based on an OSHA analysis of BLS data on workplace violence incidents. These data are summarized above in Table 14, and detailed data summarizing incidents *by incident type* (i.e., lost-work, non-lost-work, other physical, and threats) are reported in Appendix C.

The amount of time for an investigation of a violent incident, in the agency's judgment, varies by type (severity) of incident but not by type or size of facility. OSHA allocated total labor burden to a mix of management and patient contact/care occupation categories, reflecting their joint participation in the process.

Table 29 presents OSHA's estimate of the per-incident labor burden, by incident type and labor category, for incident investigations.

Table 22. Incident Investigation Labor Burden per Incident

Type of WPV Incident and Labor Category	Investigation Hours (per Incident)
Lost Work Incidents	
Patient Care/Contact Employee	2
Management/Supervisor Employee	4
Non-Lost Work Incidents	
Patient Care/Contact Employee	1.5
Management/Supervisor Employee	3
Other Physical	
Patient Care/Contact Employee	1
Management/Supervisor Employee	2
Threats	
Patient Care/Contact Employee	0.5
Management/Supervisor Employee	1

Source: OSHA, 2023.

OSHA estimated total labor burden per facility by taking the product of the number of incidents by type and the associated investigation labor assumptions above; this burden was then monetized using manager and employee wages.

Table 30 summarizes per-facility costs for investigating each workplace violence incident.

Table 23. Incident Investigation Burden and Cost per Facility, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621112	Offices of Physicians, Mental Health Specialists	0.6	$50	0.0	$1	0.0	$1
621330	Offices of Mental Health Practitioners	1.2	$89	0.1	$5	0.0	$3
621420	Outpatient Mental Health and Substance Abuse	1.0	$64	0.5	$29	0.1	$7
621493	Freestanding Ambulatory Surgical, Emergency	0.6	$44	0.3	$24	0.2	$11
621610	Home Health Care Services	0.8	0.8	0.3	$0	0.0	$0
621910	Ambulance Services	0.8	0.8	0.5	$0	0.1	$0
622110	General Medical and Surgical Hospitals	107.2	$8,730	13.9	$1,133	0.2	$19
622210	Psychiatric and Substance Abuse Hospitals	484.2	$34,765	92.2	$6,620	5.0	$360
622310	Specialty Hospitals (excl. Psychiatric, Substance)	47.7	$3,908	6.9	$567	0.3	$29
623110	Nursing Care Facilities (Skilled Nursing Facilities)	7.6	$451	4.8	$286	0.3	$16
623210	Residential Intellectual, Developmental Disability	10.6	$372	3.3	$115	2.4	$84
623220	Residential Mental Health and Substance Abuse	14.2	$712	4.6	$229	1.6	$79
623311	Continuing Care Retirement Communities	5.7	$275	2.4	$118	0.3	$13
623312	Assisted Living Facilities for the Elderly	2.1	$103	0.6	$29	0.2	$11
623990	Other Residential Care Facilities	43.0	$1,856	6.6	$283	3.6	$155
624110	Child and Youth Services	16.6	$17	1.7	$2	1.1	$1
624120	Services for Elderly and Persons with Disabilities	4.8	$5	1.0	$1	0.2	$0
624190	Other Individual and Family Services	4.2	$4	0.3	$0	0.2	$0
624210	Community Food Services	0.4	$0	0.2	$0	0.1	$0
624221	Temporary Shelters	NA	NA	0.8	$1	0.3	$0
624229	Other Community Housing Services	0.8	$1	0.5	$0	0.2	$0
624230	Emergency and Other Relief Services	1.2	$1	0.2	$0	0.1	$0
624310	Vocational Rehabilitation Services	5.3	$5	1.9	$2	0.4	$0
	Firefighter-EMTs	4.5	$270	0.5	$28	0.2	$14

Source: OSHA, 2023.

2.6.2 Violent Incident Log and Record Retention Costs

As with investigations, per-incident and facility costs for creation of the incident log are a function of the estimated number of incidents per facility, by incident type, and an estimated labor burden per type of incident. OSHA estimates that reportable lost-work and non-lost-work incidents require 10 minutes per incident to create a log entry, while less severe incidents (other physical and threat incidents) require 5 minutes. A log entry is assumed to be created by a manager and hence the labor burden was monetized using manager wage rates. OSHA invites comments from SERs on OSHA's preliminary unit time estimates and, broadly, on the

observations by SERs on the practice of logging and retaining reportable WPV incidents.

For employer maintenance of records for all hazard assessment and incident investigations, OSHA estimated a per-record labor burden of 5 minutes (0.08 hours) per year. Estimated annual labor burden per facility for record retention was monetized using clerical wages.

Table 31 summarizes facility costs for recordkeeping (i.e., incident log creation and records retention.)

Table 24. Recordkeeping Burden and Cost per Facility, all Ownerships

NAICS	NAICS Description	Large		Small		Very Small	
		Hours	Cost	Hours	Cost	Hours	Cost
621112	Offices of Physicians, Mental Health Specialists	0.04	$1.08	0.00	$0.02	0.00	$0.02
621330	Offices of Mental Health Practitioners	0.08	$2.19	0.00*	$0.12	0.00*	$0.06
621420	Outpatient Mental Health and Substance Abuse	0.07	$1.93	0.03	$0.88	0.01	$0.23
621493	Freestanding Ambulatory Surgical, Emergency	0.04	$1.23	0.02	$0.68	0.01	$0.31
621610	Home Health Care Services	0.8	0.8	0.27	$0.27	0.05	$0.05
621910	Ambulance Services	0.8	0.8	0.46	$0.46	0.15	$0.15
622110	General Medical and Surgical Hospitals	7.08	$207.00	0.92	$26.87	0.02	$0.45
622210	Psychiatric and Substance Abuse Hospitals	31.44	$955.16	5.99	$181.87	0.33	$9.90
622310	Specialty Hospitals (excl. Psychiatric, Substance)	3.11	$92.14	0.45	$13.37	0.02	$0.67
623110	Nursing Care Facilities (Skilled Nursing Facilities)	0.50	$14.62	0.32	$9.28	0.02	$0.52
623210	Residential Intellectual, Developmental Disability	0.70	$20.27	0.21	$6.25	0.16	$4.57
623220	Residential Mental Health and Substance Abuse	0.93	$27.82	0.30	$8.96	0.10	$3.10
623311	Continuing Care Retirement Communities	0.37	$10.95	0.16	$4.71	0.02	$0.50
623312	Assisted Living Facilities for the Elderly	0.14	$4.12	0.04	$1.17	0.01	$0.42
623990	Other Residential Care Facilities	2.80	$82.10	0.43	$12.54	0.23	$6.88
624110	Child and Youth Services	16.61	$16.61	1.67	$1.67	1.14	$1.14
624120	Services for Elderly and Persons with Disabilities	4.76	$4.76	0.98	$0.98	0.19	$0.19
624190	Other Individual and Family Services	4.19	$4.19	0.33	$0.33	0.21	$0.21
624210	Community Food Services	0.43	$0.43	0.24	$0.24	0.13	$0.13
624221	Temporary Shelters	NA	NA	0.76	$0.76	0.29	$0.29
624229	Other Community Housing Services	0.80	$0.80	0.49	$0.49	0.23	$0.23
624230	Emergency and Other Relief Services	1.22	$1.22	0.23	$0.23	0.12	$0.12
624310	Vocational Rehabilitation Services	5.30	$5.30	1.91	$1.91	0.36	$0.36
	Firefighter-EMTs	0.29	$8.15	0.03	$0.84	0.01	$0.42

Source: OSHA, 2023.
* = appears as zero due to rounding.

3. Total Costs

3.1 Introduction

This chapter brings together information from the industry profile and unit cost analysis to estimate the industry-level total cost of compliance with the regulatory framework. Per-establishment unit costs were estimated at the industry level based on the total number of establishments by industry, ownership, and establishment size. The total cost analysis also accounts for baseline compliance for each requirement, and the time profile of one-time and recurring costs span a ten-year period. Here, recurring costs that are related to the number of incidents do not change over time and thus are an over-estimate because the regulatory framework is expected to result in a decrease in the number of incidents.

All costs presented here are annualized. Annualized costs take a standard 10-year horizon of initial one-time costs and nine years of annual recurring costs and reflect a constant annual equivalent for each of the ten years. Analogous to paying off a loan with constant yearly payments worth the present value of the ten years' worth of costs, annualized cost depends positively on the discount rate used. Total and per-facility annualized costs were estimated using both a three-percent and seven-percent discount rate. Table 32 summarizes the annualized costs of the rule by paragraph and presents an estimated total cost of $1.22 billion per year using a three percent discount rate. Not shown in Table 32 are annualized costs at a seven-percent discount rate: $1.25 billion. Training is by far the largest cost element, making up 75 percent of the total cost.

Table 25. Total Annualized Costs

Draft Rule Provision	Total Annualized Cost, millions, $2019, 3% discount rate*	Percentage of Total Cost*
Paragraph (c) – Workplace Violence Prevention Plan	$65.1	5.4%
Paragraph (d) – Workplace Hazard Assessment	$63.6	5.2%
Paragraph (e) – Controls	$104.8	8.6%
Paragraph (f) – Training	$908.8	74.7%
Paragraph (g) – Violent Incident Reporting	$73.5	6.0%
Total	$1,215.9	100.0%

Source: OSHA, 2023.
*Due to rounding, figures in this column may not sum to the total shown.

3.2 Baseline

Total costs of the proposed regulatory framework must take into account a compliance baseline to capture current practices among affected facilities for each of the potential regulatory provisions. Practices already in place are not new costs in relation to implementation of the potential proposed rule and therefore would need to be deducted to estimate the cost of the potential proposed rule. OSHA consulted healthcare facility management and security experts in order to specify baseline compliance (Abt, 2020). Table 33 presents the estimated degree of compliance with a given requirement across the overall population of facilities in a given

healthcare setting, where percentages reflect the reality that some facilities may be in compliance with only a subset of the section's requirements. For example, even though most employers likely conducted some sort of post-incident investigation, many might not have focused on the specific information required by the draft rule or involved employees as required by the draft rule. Those employers would not be considered in compliance for baseline purposes.

Table 26. Baseline Compliance Rates, by Potential Rule Requirement and Setting

Potential Rule Provision	Baseline Compliance					
	Behavioral Health	Other Hospitals	Residential Care	Home Healthcare	Social Assistance	Emergency Response
Paragraph (c), WVPP	45%	28%	41%	30%	20%	36%
Paragraph (d), Hazard Assessment	30%	40%	30%	20%	20%	30%
Paragraph (e) Controls	48%	66%	37%	41%	12%	48%
Paragraph (f) Training	65%	50%	35%	25%	50%	44%
Paragraph (g)(2) & (g)(3) Investigation	50%	50%	35%	25%	10%	40%
Paragraph (g)(4), Recordkeeping	60%	75%	50%	50%	10%	59%

Source: OSHA consultation with subject matter experts. See Abt's September 10, 2020 memorandum, "Workplace Violence in the Healthcare and Social Assistance Sector: Expert Outreach for PIRFA Support."

3.3 Workplace Violence Prevention Program (WVPP)

Incremental, annualized costs for WVPP, paragraph (c) of the potential rule, are estimated based on (1) facility-level one-time and annual unit costs absent compliance (summarized in Table 34), (2) the number of affected establishments, and (3) the extent of baseline compliance with the potential rule's requirements. Table 34 presents the annualized costs for the potential rule's WVPP requirements, by NAICS industry, aggregated across all facility size and ownership categories. Total annualized costs for this requirement are estimated to be approximately $65.1 million per year.

Table 27. Annualized Costs for WVPP Requirements, all Ownerships ($2019)

NAICS	NAICS Description	Number of Establishments	Total Annualized Cost (3%)*	Annualized Cost per Establishment
621112	Offices of Physicians, Mental Health Specialists	10,817	$1,768,738	$164
621330	Offices of Mental Health Practitioners	25,370	$4,516,032	$178
621420	Outpatient Mental Health and Substance Abuse	11,969	$5,561,330	$465
621493	Freestanding Ambulatory Surgical, Emergency	7,661	$300,456	$39
621610	Home Health Care Services	33,581	$5,886,979	$175
621910	Ambulance Services	5,672	$638,587	$113
622110	General Medical and Surgical Hospitals	5,285	$7,273,456	$1,376
622210	Psychiatric and Substance Abuse Hospitals	1,442	$1,637,391	$1,136
622310	Specialty Hospitals (excl. Psychiatric, Substance)	920	$382,900	$416
623110	Nursing Care Facilities (Skilled Nursing Facilities)	17,138	$10,946,294	$639
623210	Residential Intellectual, Developmental Disability	35,218	$8,454,404	$240
623220	Residential Mental Health and Substance Abuse	8,084	$3,962,507	$490
623311	Continuing Care Retirement Communities	5,570	$2,148,146	$386

NAICS	NAICS Description	Number of Establishments	Total Annualized Cost (3%)*	Annualized Cost per Establishment
623312	Assisted Living Facilities for the Elderly	20,052	$2,386,025	$119
623990	Other Residential Care Facilities	5,371	$416,180	$77
624110	Child and Youth Services	12,278	$1,135,476	$92
624120	Services for Elderly and Persons with Disabilities	35,075	$3,232,048	$92
624190	Other Individual and Family Services	29,937	$2,427,326	$81
624210	Community Food Services	4,790	$155,548	$32
624221	Temporary Shelters	4,287	$289,900	$68
624229	Other Community Housing Services	4,696	$205,663	$44
624230	Emergency and Other Relief Services	1,112	$95,811	$86
624310	Vocational Rehabilitation Services	8,011	$1,053,675	$132
	Firefighter EMTs	6,110	$228,181	$37
Total		300,447	$65,103,053	Avg.: $217

Source: OSHA, 2023.
*Due to rounding, figures in this column may not sum to the total shown.

3.4 Workplace Hazard Assessment

Using the three-step methodology described immediately above for aggregating costs of workplace violence prevention programs, OSHA combined the facility-level costs of compliance for hazard assessments summarized in Table 21 with the number of affected establishments and estimated baseline compliance to calculate total costs for workplace hazard assessments. Table 35 presents the annualized costs of compliance for the potential rule's hazard assessment requirements, by industry, for all sizes and ownerships. Annualized costs for hazard assessments are estimated to total approximately $63.6 million per year.

Table 28. Annualized Compliance Costs for Hazard Assessments, all Ownerships ($2019)

NAICS	NAICS Description	Number of Establishments	Total Annualized Cost (3%)*	Annualized Cost per Establishment
621112	Offices of Physicians, Mental Health Specialists	10,817	$528,496	$49
621330	Offices of Mental Health Practitioners	25,370	$1,391,004	$55
621420	Outpatient Mental Health and Substance Abuse	11,969	$1,995,413	$167
621493	Freestanding Ambulatory Surgical, Emergency	7,661	$399,394	$52
621610	Home Health Care Services	33,581	$4,464,891	$133
621910	Ambulance Services	5,672	$475,073	$84
622110	General Medical and Surgical Hospitals	5,285	$12,960,947	$2,452
622210	Psychiatric and Substance Abuse Hospitals	1,442	$7,852,151	$5,446
622310	Specialty Hospitals (excl. Psychiatric, Substance)	920	$748,170	$813
623110	Nursing Care Facilities (Skilled Nursing Facilities)	17,138	$12,845,214	$750
623210	Residential Intellectual, Developmental Disability	35,218	$4,474,628	$127
623220	Residential Mental Health and Substance Abuse	8,084	$1,668,249	$206
623311	Continuing Care Retirement Communities	5,570	$2,490,234	$447
623312	Assisted Living Facilities for the Elderly	20,052	$2,746,497	$137

NAICS	NAICS Description	Number of Establishments	Total Annualized Cost (3%)*	Annualized Cost per Establishment
623990	Other Residential Care Facilities	5,371	$768,081	$143
624110	Child and Youth Services	12,278	$1,134,849	$92
624120	Services for Elderly and Persons with Disabilities	35,075	$2,583,642	$74
624190	Other Individual and Family Services	29,937	$2,013,547	$67
624210	Community Food Services	4,790	$128,121	$27
624221	Temporary Shelters	4,287	$242,166	$56
624229	Other Community Housing Services	4,696	$171,929	$37
624230	Emergency and Other Relief Services	1,112	$79,048	$71
624310	Vocational Rehabilitation Services	8,011	$945,856	$118
	Firefighter EMTs	6,110	$517,238	$85
Total		300,447	$63,624,837	Avg.: $212

Source: OSHA, 2023.
*Due to rounding, figures in this column may not sum to the total shown.

3.5 Controls

Table 36 summarizes the annualized costs of compliance for the potential rule's control requirements, which includes costs both for implementation of controls and for staff time during incident response, by industry, for all sizes and ownerships. Total annualized costs for controls are estimated to be approximately $104.8 million per year.

Table 29. Annualized Compliance Costs for Controls, all Ownerships ($2019)

NAICS	NAICS Description	Number of Establishments	Total Annualized Cost (3%)*	Annualized Cost per Establishment
621112	Offices of Physicians, Mental Health Specialists	10,817	$1,252,689	$116
621330	Offices of Mental Health Practitioners	25,370	$3,146,642	$124
621420	Outpatient Mental Health and Substance Abuse	11,969	$3,271,226	$273
621493	Freestanding Ambulatory Surgical, Emergency	7,661	$630,395	$82
621610	Home Health Care Services	33,581	$1,002,596	$30
621910	Ambulance Services	5,672	$109,874	$19
622110	General Medical and Surgical Hospitals	5,285	$17,842,473	$3,376
622210	Psychiatric and Substance Abuse Hospitals	1,442	$8,918,334	$6,186
622310	Specialty Hospitals (excl. Psychiatric, Substance)	920	$919,362	$999
623110	Nursing Care Facilities (Skilled Nursing Facilities)	17,138	$22,684,658	$1,324
623210	Residential Intellectual, Developmental Disability	35,218	$11,726,934	$333
623220	Residential Mental Health and Substance Abuse	8,084	$3,020,326	$374
623311	Continuing Care Retirement Communities	5,570	$5,594,768	$1,004
623312	Assisted Living Facilities for the Elderly	20,052	$5,951,182	$297
623990	Other Residential Care Facilities	5,371	$1,515,228	$282
624110	Child and Youth Services	12,278	$3,695,758	$301

NAICS	NAICS Description	Number of Establishments	Total Annualized Cost (3%)*	Annualized Cost per Establishment
624120	Services for Elderly and Persons with Disabilities	35,075	$919,380	$26
624190	Other Individual and Family Services	29,937	$7,473,503	$250
624210	Community Food Services	4,790	$430,673	$90
624221	Temporary Shelters	4,287	$569,521	$133
624229	Other Community Housing Services	4,696	$470,572	$100
624230	Emergency and Other Relief Services	1,112	$272,763	$245
624310	Vocational Rehabilitation Services	8,011	$3,188,242	$398
	Firefighter EMTs	6,110	$157,412	$26
Total		300,447	$104,764,511	Avg.: $349

Source: OSHA, 2023.
*Due to rounding, figures in this column may not sum to the total shown.

3.6 Training

For this PIRFA, the number of employees in each NAICS industry and size is held constant over time. In year one of the analysis, costs are incurred based on initial training unit costs. In subsequent years of the analysis, the total cost reflects a mix of employees participating in initial and refresher training, based on employment turnover, as described in 2.5.1.

Table 37 summarizes the annualized costs of compliance for the potential rule's training requirements, by industry, for all sizes and ownerships. Total annualized costs for training are estimated to be approximately $909 million per year.

Table 30. Annualized Compliance Costs for Training, all Ownerships ($2019)

NAICS	NAICS Description	Number of Establishments	Total Annualized Cost (3%)*	Annualized Cost per Establishment
621112	Offices of Physicians, Mental Health Specialists	10,817	$7,168,000	$663
621330	Offices of Mental Health Practitioners	25,370	$14,721,411	$580
621420	Outpatient Mental Health and Substance Abuse	11,969	$18,305,809	$1,529
621493	Freestanding Ambulatory Surgical, Emergency	7,661	$10,647,296	$1,390
621610	Home Health Care Services	33,581	$109,508,903	$3,261
621910	Ambulance Services	5,672	$8,917,289	$1,572
622110	General Medical and Surgical Hospitals	5,285	$357,400,337	$67,624
622210	Psychiatric and Substance Abuse Hospitals	1,442	$15,628,513	$10,840
622310	Specialty Hospitals (excl. Psychiatric, Substance)	920	$15,224,073	$16,546
623110	Nursing Care Facilities (Skilled Nursing Facilities)	17,138	$126,541,831	$7,384
623210	Residential Intellectual, Developmental Disability	35,218	$28,729,730	$816
623220	Residential Mental Health and Substance Abuse	8,084	$11,148,608	$1,379
623311	Continuing Care Retirement Communities	5,570	$25,366,564	$4,554
623312	Assisted Living Facilities for the Elderly	20,052	$25,602,648	$1,277
623990	Other Residential Care Facilities	5,371	$6,772,222	$1,261

NAICS	NAICS Description	Number of Establishments	Total Annualized Cost (3%)*	Annualized Cost per Establishment
624110	Child and Youth Services	12,278	$8,908,347	$726
624120	Services for Elderly and Persons with Disabilities	35,075	$72,965,519	$2,080
624190	Other Individual and Family Services	29,937	$19,279,291	$644
624210	Community Food Services	4,790	$1,456,440	$304
624221	Temporary Shelters	4,287	$2,462,428	$574
624229	Other Community Housing Services	4,696	$1,838,122	$391
624230	Emergency and Other Relief Services	1,112	$800,972	$720
624310	Vocational Rehabilitation Services	8,011	$7,488,143	$935
	Firefighter EMTs	6,110	$11,928,163	$1,953
Total		300,447	$908,810,660	Avg.: $3,025

Source: OSHA, 2023.
*Due to rounding, figures in this column may not sum to the total shown.

3.7 Violent Incident Investigation and Recordkeeping

Incremental, annualized compliance costs for violent incident investigation are based on annual per-facility incident investigation costs, previously summarized in Table 30. This PIRFA assumes a constant number of incidents per year, based on the analysis presented in Appendix C. Incremental costs for recordkeeping are similarly based on per-facility recordkeeping costs, summarized in Table 31.

In both cases, per-facility costs were scaled to the industry level based on the number of establishments, and adjusted to reflect the degree of baseline compliance specified in Table 33. Recordkeeping costs reflect the annual monetized burden of establishing and maintaining a log of violent incidents.

Table 38 summarizes the annualized costs of compliance for the potential rule's investigation and recordkeeping requirements, by NAICS industry, for all sizes and ownerships. Total annualized costs for training are estimated to be approximately $73.5 million per year.

Table 31. Annualized Compliance Costs for Investigation and Recordkeeping, all Ownerships ($2019)

NAICS	NAICS Description	Number of Establishments	Total Annualized Cost (3%)*	Annualized Cost per Establishment
621112	Offices of Physicians, Mental Health Specialists	10,817	$6,042	$0.6
621330	Offices of Mental Health Practitioners	25,370	$62,312	$2
621420	Outpatient Mental Health and Substance Abuse	11,969	$249,749	$21
621493	Freestanding Ambulatory Surgical, Emergency	7,661	$136,148	$18
621610	Home Health Care Services	33,581	$639,341	$19
621910	Ambulance Services	5,672	$133,562	$24
622110	General Medical and Surgical Hospitals	5,285	$25,021,203	$4,734
622210	Psychiatric and Substance Abuse Hospitals	1,442	$25,599,024	$17,755
622310	Specialty Hospitals (excl. Psychiatric, Substance)	920	$2,193,155	$2,384
623110	Nursing Care Facilities (Skilled Nursing Facilities)	17,138	$4,057,507	$237

NAICS	NAICS Description	Number of Establishments	Total Annualized Cost (3%)*	Annualized Cost per Establishment
623210	Residential Intellectual, Developmental Disability	35,218	$4,858,675	$138
623220	Residential Mental Health and Substance Abuse	8,084	$1,617,682	$200
623311	Continuing Care Retirement Communities	5,570	$593,569	$107
623312	Assisted Living Facilities for the Elderly	20,052	$623,251	$31
623990	Other Residential Care Facilities	5,371	$2,043,314	$380
624110	Child and Youth Services	12,278	$1,849,267	$151
624120	Services for Elderly and Persons with Disabilities	35,075	$1,553,607	$44
624190	Other Individual and Family Services	29,937	$871,141	$29
624210	Community Food Services	4,790	$53,159	$11
624221	Temporary Shelters	4,287	$132,477	$31
624229	Other Community Housing Services	4,696	$94,293	$20
624230	Emergency and Other Relief Services	1,112	$31,280	$28
624310	Vocational Rehabilitation Services	8,011	$914,620	$114
	Firefighter EMTs	6,110	$215,546	$35
Total		300,447	$73,549,924	Avg.: $245

Source: OSHA, 2023.
*Due to rounding, figures in this column may not sum to the total shown.

3.8 Summary of Total Costs

Table 39 presents the draft regulatory framework's total cost by NAICS code. These costs include all aspects of the rule and all facilities. Total cost is estimated to be $1.22 billion per year, at a 3 percent discount rate, for the 300,447 affected establishments. Total cost is $1.25 billion per year with a seven percent discount rate.

Table 32. Summary of Total Annualized Costs for the Draft Rule, by NAICS ($2019)

Setting and NAICS, All Ownerships	NAICS Description	Number of Establishments	Annualized Cost, All Rule Provisions(3% rate)*	Annualized Cost per Establishment, (3% rate)
Behavioral Health		92,900	$203,242,049	$2,188
621112	Offices of Physicians, Mental Health Specialists	10,817	$10,723,964	$991
621330	Offices of Mental Health Practitioners (except Physicians)	25,370	$23,837,401	$940
621420	Outpatient Mental Health and Substance Abuse Centers	11,969	$29,383,527	$2,455
622210	Psychiatric and Substance Abuse Hospitals	1,442	$59,635,413	$41,362
623210	Residential Intellectual and Developmental Disability	35,218	$58,244,372	$1,654
623220	Residential Mental Health and Substance Abuse Facilities	8,084	$21,417,372	$2,649
Other Hospitals (excluding Behavioral Health)		13,866	$452,079,765	$32,604
621493	Freestanding Ambulatory Surgical, Emergency Centers	7,661	$12,113,688	$1,581

Setting and NAICS, All Ownerships	NAICS Description	Number of Establishments	Annualized Cost, All Rule Provisions(3% rate)*	Annualized Cost per Establishment, (3% rate)
622110	General Medical and Surgical Hospitals	5,285	$420,498,417	$79,563
622310	Specialty (except Psych and Substance) Hospitals	920	$19,467,660	$21,157
Residential Care Facilities		48,131	$262,093,414	$5,445
623110	Nursing Care Facilities (Skilled Nursing Facilities)	17,138	$177,075,504	$10,332
623311	Continuing Care Retirement Communities	5,570	$36,193,282	$6,498
623312	Assisted Living Facilities for the Elderly	20,052	$37,309,603	$1,861
623990	Other Residential Care Facilities	5,371	$11,515,025	$2,144
Social Assistance		65,111	$72,359,927	$1,111
624110	Child and Youth Services	12,278	$16,723,697	$1,362
624190	Other Individual and Family Services	29,937	$32,064,808	$1,071
624210	Community Food Services	4,790	$2,223,941	$464
624221	Temporary Shelters	4,287	$3,696,492	$862
624229	Other Community Housing Services	4,696	$2,780,579	$592
624230	Emergency and Other Relief Services	1,112	$1,279,874	$1,150
624310	Vocational Rehabilitation Services	8,011	$13,590,536	$1,696
Home Healthcare Services		68,656	$202,756,907	$2,953
621610	Home Health Care Services	33,581	$121,502,711	$3,618
624120	Services for the Elderly and Persons with Disabilities	35,075	$81,254,196	$2,317
Emergency Response		11,782	$23,320,923	$1,979
621910	Ambulance Services	5,672	$10,274,385	$1,811
	Firefighter-EMTs	6,110	$13,046,539	$2,135
All Entities		300,447	$1,215,852,985	$4,047

Source: OSHA, 2023.
*Due to rounding, figures in this column may not sum to the total shown.

The preceding discussion focused on the total costs of the draft regulatory framework for affected industries. To provide an estimate of the economic significance of the impacts of these costs, OSHA examined the annualized costs of the draft standard versus revenues and profits, for each affected industry. OSHA uses a minimum threshold level of annualized compliance costs equal to one percent of annual revenues—and, secondarily, annualized compliance costs equal to ten percent of annual profits—below which the agency typically concludes, in the absence of special circumstances, that the costs are unlikely to threaten the feasibility and survival of the industry as a whole. The agency then repeats this analysis for small entities and very small entities. Here the agency typically uses the same threshold of one percent of revenues, but a stricter threshold of ten percent of profits, to investigate whether a significant number of smaller entities might be economically threatened and the overall competitive structure of an industry might be altered for the worse.

These comparisons were made based on each entity's NAICS code, ownership, and size classification. Average revenue was estimated using total receipts and total entities from CBP 2017 data, as described in Section 1.3. Average profits were derived by applying a NAICS-specific profit rate to each average revenue estimate. The profit rates were calculated using 2004 – 2013 data from the 2013 Corporation Source Book, the most recent data available (Internal Revenue Service, 2019). All values were adjusted to 2019 dollars using the GDP implicit price deflator from BEA (BEA 2019). OSHA requests feedback from SERs regarding whether the profit-rate screen remains a useful screen for this rulemaking and whether an alternative screen would be more appropriate for employers potentially affected by this draft rule.

The IRS data are limited in the detail of their industry breakdown, and so each six-digit NAICS code was mapped to one of three possible three-digit NAICS code values from the IRS data. These data include the total receipts and net income for available industry codes. Profit rates were calculated by dividing the net income by total receipts for each industry sector, and averaged over the 2004 through 2013 time span to calculate an average profit rate to apply to the average revenue figures. Table 40 shows these rates as well as the mapping of profit rates to healthcare settings, and hence six-digit NAICS code, used in the analysis.

Table 40. Profit Rates, by NAICS (percent of total revenue)

3-Digit NAICS	NAICS Description	Map to Healthcare Setting	Profit Rate (% of revenue)
621	Offices of Practitioners and Outpatient Care Centers	Behavioral Health	6.6%
625	Misc. Health Care and Social Assistance	Home Health, Social Assistance, Emergency Responders	6.4%
626	Hospitals, Nursing, and Residential Care Facilities	Other Hospitals, Residential Care	4.3%

Source: OSHA, 2023.

4.1 Summary of All Entity Impacts

Table 41 presents impacts for *all* for-profit, non-profit, and local government entities. These costs include all aspects of the rule. Total cost for these entities is estimated to be $1.13 billion per year, at a 3 percent discount rate, for the 197,939 affected entities. None of the affected industries show incremental impacts exceeding one percent of revenues or ten percent of profits.

Table 33. Summary of All Entity Cost and Impacts, by NAICS ($2019)

Setting, Size, and NAICS	NAICS Description	Entities	Revenue per Entity	Profit per Entity	Cost per Entity	Cost / Rev.	Cost / Profit
Behavioral Health		52,934	$1,882,462	$124,155	$2,844	0.15%	2.29%
621112	Offices of Physicians, Mental Health Specialists	10,565	$564,176	$37,209	$1,014	0.18%	2.72%
621330	Offices of Mental Health Practitioners (except Physicians)	24,251	$388,409	$25,617	$983	0.25%	3.84%
621420	Outpatient Mental Health and Substance Abuse Centers	6,623	$3,507,978	$231,363	$4,399	0.13%	1.90%
622210	Psychiatric and Substance Abuse Hospitals	299	$48,168,028	$3,176,843	$57,602	0.12%	1.81%
623210	Residential Intellectual and Developmental Disability Facilities	6,982	$4,167,280	$274,846	$7,047	0.17%	2.56%
623220	Residential Mental Health and Substance Abuse Facilities	4,213	$4,157,146	$274,178	$4,841	0.12%	1.77%
Other Hospitals		7,527	$130,289,473	$5,653,141	$57,239	0.04%	1.01%
621493	Freestanding Ambulatory Surgical and Emergency Centers	4,401	$7,270,767	$315,472	$2,752	0.04%	0.87%
622110	General Medical and Surgical Hospitals	2,806	$324,655,891	$14,086,523	$143,726	0.04%	1.02%
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	319	$117,766,436	$5,109,778	$48,187	0.04%	0.94%
Residential Care		30,709	$6,635,043	$287,888	$8,416	0.13%	2.92%
623110	Nursing Care Facilities (Skilled Nursing Facilities)	9,255	$13,852,322	$601,040	$18,971	0.14%	3.16%
623311	Continuing Care Retirement Communities	3,882	$9,257,663	$401,682	$9,276	0.10%	2.31%
623312	Assisted Living Facilities for the Elderly	14,346	$2,161,951	$93,805	$2,587	0.12%	2.76%
623990	Other Residential Care Facilities	3,226	$2,664,974	$115,631	$3,026	0.11%	2.62%
Social Assistance		46,247	$2,331,422	$148,502	$1,450	0.06%	0.98%
624110	Child and Youth Services	8,962	$2,006,137	$127,783	$1,622	0.08%	1.27%
624190	Other Individual and Family Services	22,003	$1,789,328	$113,973	$1,343	0.08%	1.18%
624210	Community Food Services	3,505	$3,248,551	$206,920	$635	0.02%	0.31%
624221	Temporary Shelters	3,336	$1,887,067	$120,199	$1,108	0.06%	0.92%
624229	Other Community Housing Services	3,633	$2,095,263	$133,460	$765	0.04%	0.57%
624230	Emergency and Other Relief Services	627	$18,505,848	$1,178,750	$2,040	0.01%	0.17%
624310	Vocational Rehabilitation Services	4,180	$3,245,308	$206,713	$3,114	0.10%	1.51%
Home Healthcare		51,491	$2,747,489	$175,004	$3,921	0.14%	2.24%
621610	Home Health Care Services	23,851	$3,671,192	$233,840	$5,094	0.14%	2.18%
624120	Services for the Elderly and Persons with Disabilities	27,640	$1,950,408	$124,233	$2,908	0.15%	2.34%
Emergency Response		9,032	$4,602,684	$293,173	$2,553	0.06%	0.87%
621910	Ambulance Services	3,230	$5,269,214	$335,628	$3,181	0.06%	0.95%
Firefighter-EMTs	Firefighter-EMTs	5,801	$4,231,545	$269,533	$2,204	0.05%	0.82%
All Entities		197,939	$7,956,552	$386,427	$5,718	0.07%	1.48%

Source: OSHA, 2023.

4.2 Summary of SBA-Defined Small Entity and Very Small Entity Impacts

Table 42 presents impacts for all SBA-defined small entities. These costs include all aspects of the rule. Total cost for all SBA-small entities is estimated to be $820.0 million per year, at a 3 percent discount rate, for the 192,016 affected small entities. The incremental annualized cost of compliance with the potential proposed rule for the average affected small entity is estimated to be $4,271 in 2019 dollars. Table 43 presents a summary of results for very small entities. The incremental annualized cost of compliance with the final rule for the average affected very small entity is estimated to be $479 in 2019 dollars (Table 43). None of the affected industries for either SBA-small or very small entities show incremental impacts exceeding one percent of revenues or ten percent of profits.

Table 34. Summary of Small Entity Cost and Impacts, All SBA-Defined Small Entities, by NAICS ($2019)

Setting, Size, and NAICS	NAICS Description	Small Entities	Revenue per Entity	Profit per Entity	Cost per Entity	Cost / Rev.	Cost / Profit
Behavioral Health		52,174	$1,538,876	$101,494	$2,372	0.15%	2.34%
621112	Offices of Physicians, Mental Health Specialists	10,562	$563,190	$37,144	$1,013	0.18%	2.73%
621330	Offices of Mental Health Practitioners (except Physicians)	24,240	$386,518	$25,492	$980	0.25%	3.85%
621420	Outpatient Mental Health and Substance Abuse Centers	6,383	$3,164,819	$208,730	$3,951	0.12%	1.89%
622210	Psychiatric and Substance Abuse Hospitals	193	$32,876,587	$2,168,321	$39,019	0.12%	1.80%
623210	Residential Intellectual and Developmental Disability Facilities	6,731	$3,540,301	$233,495	$5,912	0.17%	2.53%
623220	Residential Mental Health and Substance Abuse Facilities	4,065	$3,588,254	$236,657	$4,115	0.11%	1.74%
Other Hospitals		6,277	$120,706,409	$5,237,341	$53,090	0.04%	1.01%
621493	Freestanding Ambulatory Surgical and Emergency Centers	3,934	$3,873,352	$168,061	$1,475	0.04%	0.88%
622110	General Medical and Surgical Hospitals	2,161	$334,031,072	$14,493,304	$147,615	0.04%	1.02%
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	182	$112,646,609	$4,887,634	$46,185	0.04%	0.94%
Residential Care		29,434	$4,203,333	$182,379	$5,305	0.13%	2.91%
623110	Nursing Care Facilities (Skilled Nursing Facilities)	8,623	$8,163,473	$354,206	$11,271	0.14%	3.18%
623311	Continuing Care Retirement Communities	3,661	$7,850,202	$340,613	$7,892	0.10%	2.32%
623312	Assisted Living Facilities for the Elderly	14,001	$1,186,166	$51,467	$1,497	0.13%	2.91%
623990	Other Residential Care Facilities	3,149	$2,533,806	$109,940	$2,890	0.11%	2.63%
Social Assistance		45,614	$2,240,089	$142,685	$1,380	0.06%	0.97%
624110	Child and Youth Services	8,842	$1,904,250	$121,293	$1,540	0.08%	1.27%
624190	Other Individual and Family Services	21,651	$1,655,678	$105,460	$1,252	0.08%	1.19%
624210	Community Food Services	3,493	$3,224,984	$205,419	$631	0.02%	0.31%
624221	Temporary Shelters	3,336	$1,887,067	$120,199	$1,108	0.06%	0.92%
624229	Other Community Housing Services	3,619	$2,096,715	$133,552	$766	0.04%	0.57%
624230	Emergency and Other Relief Services	618	$18,517,695	$1,179,504	$2,040	0.01%	0.17%
624310	Vocational Rehabilitation Services	4,055	$3,182,149	$202,690	$3,033	0.10%	1.50%
Home Healthcare		50,020	$1,768,113	$112,622	$2,597	0.15%	2.31%
621610	Home Health Care Services	23,122	$1,983,280	$126,327	$2,986	0.15%	2.36%
624120	Services for the Elderly and Persons with Disabilities	26,898	$1,583,154	$100,841	$2,263	0.14%	2.24%
Emergency Response		8,497	$2,570,871	$163,754	$1,650	0.06%	1.01%
621910	Ambulance Services	3,113	$3,171,965	$202,042	$2,055	0.06%	1.02%
Firefighter-EMTs	Firefighter-EMTs	5,384	$2,223,294	$141,615	$1,415	0.06%	1.00%
All SBA-Small Entities		192,016	$6,114,919	$297,225	$4,271	0.07%	1.44%

Source: OSHA, 2022.

Table 35. Summary of Very Small Entity Cost and Impacts, by NAICS ($2019)

Setting, Size, and NAICS	NAICS Description	Very Small Entities	Revenue per Entity	Profit per Entity	Cost per Entity	Cost / Rev.	Cost / Profit
Behavioral Health		42,934	$333,138	$21,972	$559	0.17%	2.54%
621112	Offices of Physicians, Mental Health Specialists	10,164	$415,575	$27,409	$666	0.16%	2.43%
621330	Offices of Mental Health Practitioners (except Physicians)	23,019	$240,912	$15,889	$499	0.21%	3.14%
621420	Outpatient Mental Health and Substance Abuse Centers	4,120	$503,658	$33,218	$628	0.12%	1.89%
622210	Psychiatric and Substance Abuse Hospitals	16	$2,452,646	$161,760	$689	0.03%	0.43%
623210	Residential Intellectual and Developmental Disability Facilities	3,599	$350,847	$23,140	$533	0.15%	2.30%
623220	Residential Mental Health and Substance Abuse Facilities	2,016	$573,600	$37,831	$606	0.11%	1.60%
Other Hospitals		2,746	$1,679,628	$72,878	$581	0.03%	0.80%
621493	Freestanding Ambulatory Surgical and Emergency Centers	2,651	$1,444,387	$62,671	$588	0.04%	0.94%
622110	General Medical and Surgical Hospitals	75	$10,130,404	$439,549	$375	0.00%	0.09%
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	20	$1,164,409	$50,523	$325	0.03%	0.64%
Residential Care		15,897	$461,694	$20,032	$519	0.11%	2.59%
623110	Nursing Care Facilities (Skilled Nursing Facilities)	2,193	$979,550	$42,502	$606	0.06%	1.43%
623311	Continuing Care Retirement Communities	1,365	$503,620	$21,852	$564	0.11%	2.58%
623312	Assisted Living Facilities for the Elderly	10,464	$359,287	$15,589	$480	0.13%	3.08%
623990	Other Residential Care Facilities	1,875	$396,947	$17,223	$600	0.15%	3.48%
Social Assistance		33,460	$493,020	$31,403	$370	0.08%	1.18%
624110	Child and Youth Services	6,706	$468,471	$29,840	$430	0.09%	1.44%
624190	Other Individual and Family Services	17,263	$388,481	$24,745	$353	0.09%	1.43%
624210	Community Food Services	2,739	$766,536	$48,825	$404	0.05%	0.83%
624221	Temporary Shelters	1,874	$517,334	$32,952	$389	0.08%	1.18%
624229	Other Community Housing Services	2,521	$888,798	$56,613	$330	0.04%	0.58%
624230	Emergency and Other Relief Services	488	$896,635	$57,112	$371	0.04%	0.65%
624310	Vocational Rehabilitation Services	1,868	$482,308	$30,721	$294	0.06%	0.96%
Home Healthcare		32,108	$356,028	$22,678	$465	0.13%	2.05%
621610	Home Health Care Services	14,862	$442,262	$28,170	$576	0.13%	2.05%
624120	Services for the Elderly and Persons with Disabilities	17,246	$281,716	$17,944	$369	0.13%	2.05%
Emergency Response		2,643	$660,144	$42,049	$554	0.08%	1.32%
621910	Ambulance Services	1,661	$548,503	$34,937	$517	0.09%	1.48%
Firefighter-EMTs	Firefighter-EMTs	982	$848,967	$54,076	$618	0.07%	1.14%
All Very-Small Entities		129,788	$430,914	$25,826	$482	0.11%	1.87%

Source: OSHA, 2022.

5. Regulatory Alternatives

This Section describes regulatory alternatives OSHA is considering. The total costs of the potential provisions are summarized in Table 44. OSHA requests comments on the need for each provision, which OSHA may or may not include a potential proposed rule.

Table 36. Total Annualized Costs by Provision ($2019)

Draft Rule Provision	Total Annualized Cost, millions, $2019, 3% discount rate
Paragraph C – Workplace Violence Prevention Plan	$65.1
Paragraph D – Workplace Hazard Assessment	$63.6
Paragraph E – Controls	$104.8
Paragraph F – Training	$908.8
Paragraph G – Violent Incident Reporting	$73.5
Total	$1,215.9

Source: OSHA, 2022.

5.1 Summary of Regulatory Alternatives

OSHA is considering several regulatory alternatives for the potential proposed rule that modify the scope and applicability of the various provisions:

5.1.1 Overall Scope Alternatives

1. **Standard applies to "patient care" only – not "patient contact"; Exempt patient contact employees from the scope of the rule. (Scope Alternative #1).** This alternative would only cover staff responsible for direct patient care, i.e., that involve hands-on or face-to face contact with patients or clients. Employees that provide support work (i.e., housekeeping, maintenance, meal delivery) would not be covered.
2. **Only include NAICS 6241, Individual and Family Services, in the Social Assistance Setting (Scope Alternative #2).** This alternative removes NAICS 6242, Community Food and Housing, and Emergency and Other Relief Services, and NAICS 6243, Vocational Rehabilitation Services, from the standard's scope.
3. **Eliminate non-fixed location sectors from the standard (Emergency Response, Home-based Healthcare & Social Assistance Services) (Scope Alternative #3).** This alternative would eliminate coverage among employees in field-based sectors (i.e. emergency medical services, home-based healthcare, home-based social assistance). Only those employed in a fixed facility (i.e. service center, hospital) would be covered.
4. **Expand scope to include locations where healthcare services are provided in correctional facilities and educational settings. (Scope Option #4).** Under this

alternative, locations with embedded healthcare services in correctional facilities and educational settings would be included in the scope of the standard.

5.1.2 Provision-Specific Alternatives

WVPP

5. **Staggered periodicity of annual review (biannually or triennially (cost change shown for latter) vs. annually) (WVPP Alternative #1).** Under this alternative, employers would review the efficacy of their program on a biennial or triennial (every two or three years, respectively) basis, rather than annually. More frequent review would only be necessary if there are changes in the workplace, such as a change in clientele, or following the investigation of a violent incident. Costs for this alternative presented here assume a triennial basis.

Hazard Assessment

6. **Reduce magnitude / size of records review for annual hazard assessments to 1 year of records (Hazard Assessment Alternative #1).** This alternative would require employers to assess 1 or 2 years-worth of workplace violence incident records in their annual hazard assessments, instead of 3 years-worth. Employers would review all workplace violence incidents, including threats of physical harm, which occurred in their facility within the previous one 1 or 2 years. Costs for this alternative presented here assume 1 years' worth of records is reviewed annually.
7. **Employers would only focus on OSHA-defined high-risk service areas and not be expected to identify additional high-risk services areas based on their experiences and recordkeeping (no separate high-risk area assessment; no incident-related assessments; keep recordkeeping, incident review) (Hazard Assessment Alternative #2).** Under this alternative, employers would not be expected to identify additional high-risk services or high-risk service areas based on their experiences and recordkeeping. The standard would exclude high-risk area hazard assessments and incident-related hazard assessments. Employers would still perform a facility-wide assessment.
8. **Change the definition of high-risk service area -- No requirement for employers to conduct establishment-wide hazard assessments based on OSHA's definitions of high-risk service areas; hazard assessments would be directed to employer-defined high-risk service areas assessments only (Hazard Assessment Alternative #3).** Under this alternative, employers would be required to define high-risk service areas rather than OSHA. This alternative would require employers to conduct subsequent hazard assessments in response to a newly-designated high-risk service area; changes in the layout, design, or amenities of the physical workplace; or changes in clientele or adding new high-risk services. The standard would exclude facility-wide hazard assessments and

incident-related hazard assessments. Employers would still perform a high-risk area hazard assessment.

Engineering Controls

9. **No Controls - Require only hazard assessment, development of a plan, and provision of training (Hazard Controls Alternative #1).** Under this alternative, the employer would not be responsible for making modifications to mitigate identified hazards and risks (i.e., implement environmental, engineering, and work-practice controls). This alternative would encourage a focus on employer-development of plan, employee participation, training, recording, and evaluation.
10. **Require only that employers implement administrative/work-practice controls -- No requirement for employers to implement environmental or engineering controls (Hazard Controls Alternative #1a).** Under this alternative, the employer would not be responsible for implementing environmental or engineering controls. This alternative would encourage a focus on administrative/work-practice controls (adjusting staffing patterns, communication practices, incident response procedures, etc.), employer-development of plan, employee participation, training, recording, and evaluation.
11. **Remove requirement for all employers to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #2).** Under this alternative, the employer would not be responsible for developing a standard operating procedure for active shooters or mass casualty situations.
12. **Remove requirement for small entities to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #3).** Under this alternative, small entities would not be responsible for developing a standard operating procedure for active shooters or mass casualty situations.

Training

13. **Remove annual training; retain initial training (Training Alternative #1).** Under this alternative, employees with patient or client contact or care would only complete an initial training, and supplemental training as necessary. Following the initial training, these employees would receive supplemental training whenever there are significant changes to any workplace violence-related procedures or controls or if employees demonstrate a need for refresher training.
14. **Require training for a more limited subset of employees (Training Alternative #2).** Under this alternative, only employees with direct patient care and violence incident response duties would be required to complete training. Employees with patient contact (i.e. physically close to patients when performing duties), not responsible for patient care, would not have to complete any training.

15. **Reduce the expected number of training hours (Training Alternative #3).** This alternative would be less strict than the proposed three-tier training program. This alternative would include different training requirements based on patient care or contact, and the hours of initial and supplemental instruction would be reduced by half.
16. **Require refresher training every 3 years or 2 years instead of annually (Training Alternatives #4 and #4a).** This alternative would require employers only perform refresher training for employees every 3 years or every 2 years.
17. **Employees specifically-designated to respond to workplace violence incidents (e.g. incident response team members) receive incident response training; all others receive the WPV training specified under the primary/default framework (Training Option #1).** Under this option, only employees with members of a workplace violence response team, or individual responders, would receive incident response training; all others receive the WPV training specified under the primary/default framework.
18. **Require 24 hours of training for small facilities (≤2 employees on site) (Training Option #2).** This option would require an advanced level of instruction for employees working in an establishment with only one or two employees on site (e.g., small behavioral health group home).
19. **Reduction of expectation of training length for the most advanced level of employee workplace violence prevention training (Training Sensitivity Test #1).** The draft regulatory text that OSHA has provided has not prescribed any specific length of time that would be associated with the various tiers of employee training curricula. However, OSHA has provided some estimates in these supplementary materials. The highest tier of training, that for those employees expected to respond to workplace violence incidents (and their supervisors), would remain the most extensive. However, a requirement to provide 24 hours of instruction would no longer be expected of any employer -- the expectation would be that employees could receive adequate instruction within a curriculum of consisting of at least 8 hours of training.

Incident Investigation & Recordkeeping

20. **Require post-incident investigations only for workplace violence incidents involving physical assault.** This alternative would only require post-incident investigations if the workplace violence incident involved physical assaults, regardless if an injury was sustained. If the violence incident does not include assault (i.e. threats), no investigation needs to be conducted.
21. **Require post-incident medical and psychological evaluations and treatment.** Under this alternative, employers incur costs to provide any required or recommended post-incident medical and psychological evaluations and treatment for the affected employee for a period of one year. The implementation of all requirements of this standard shall be

at no cost to the employee. All time required by an employee to comply with the standard, including time for training, post-incident medical and psychological evaluations/treatment, and reasonable travel time (as appropriate) shall be considered compensable time. Costs presented here assume 1 hour of evaluation per week for one year, with $5 of travel time per session; and, total alternative cost is based on average annual per employee cost applied to the estimated number of OSHA recordable incidents.

5.2 Summary of Costs for Regulatory Alternatives

Table 37. Annualized Costs for Regulatory Alternatives ($2019) Regulatory Alternative, Option, or Sensitivity Test	Change in Annualized Cost ($) (3%)	Percent Change in Annualized Cost	Annualized Cost, Alternative (3%)
Scope			
1. Standard applies to "patient care" only – not "patient contact"; Exempt patient contact employees from the scope of the rule. (Scope Alternative #1)	($23,516,110)	-1.9%	$1,192,336,875
2. Only include NAICS 6241, Individual and Family Services, in the Social Assistance Setting (Scope Alternative #2)	($23,997,530)	-2.0%	$1,191,855,456
3. Eliminate non-fixed location sectors from the standard (Emergency Response, Home-based Healthcare & Social Assistance Services) (Scope Alternative #3)	($285,391,219)	-23.5%	$930,461,766
4. Expand scope to include locations where healthcare services are provided in correctional facilities and educational settings. (Scope Option #4)	$30,155,251	2.5%	$1,246,008,236
C. WVPP			
5. Staggered periodicity of annual review (biannually or triennially (cost change shown for latter) vs. annually) (WVPP Alternative #1)	($26,818,331)	-2.2%	$1,189,034,654
D. Hazard Assessment			
6. Reduce magnitude / size of records review for annual hazard assessments to 1 year of records (Hazard Assessment Alternative #1)	($5,663,316)	-0.5%	$1,210,189,669
7. Employers would only focus on OSHA-defined high-risk service areas and not be expected to identify additional high-risk services areas based on their experiences and recordkeeping (no separate high-risk area assessment; no incident-related assessments; keep recordkeeping, incident review) (Hazard Assessment Alternative #2)	($49,264,063)	-4.1%	$1,166,588,922
8. Change the definition of high-risk service area -- No requirement for employers to conduct establishment-wide hazard assessments based on OSHA's definitions of high-risk service areas; hazard assessments would be directed to employer-defined high-risk service areas assessments only (Hazard Assessment Alternative #3)	($157,322,225)	-12.9%	$1,058,530,760
E. Hazard Controls			
9. Require only hazard assessment, development of a plan, and provision of training (Hazard Controls Alternative #1)	($101,667,773)	-8.4%	$1,114,185,212
10. Require only that employers implement administrative/work-practice controls -- No requirement for employers to implement environmental or engineering controls (Hazard Controls Alternative #1a)	($93,996,083)	-7.7%	$1,121,856,902
11. Remove requirement for all employers to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #2)	($9,965,590)	-0.8%	$1,205,887,395

Table 37. Annualized Costs for Regulatory Alternatives ($2019) Regulatory Alternative, Option, or Sensitivity Test	Change in Annualized Cost ($) (3%)	Percent Change in Annualized Cost	Annualized Cost, Alternative (3%)
12. Remove requirement for small entities to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #3)	($1,047,187)	-0.1%	$1,214,805,798
F. Training			
13. Remove annual training; retain initial training (Training Alternative #1)	($755,090,859)	-62.1%	$460,762,126
14. Require training for a more limited subset of employees (Training Alternative #2)	($19,650,597)	-1.6%	$1,196,202,388
15. Reduce the expected number of training hours (Training Alternative #3)	($454,405,330)	-37.4%	$761,447,655
16. Require refresher training every 3 years instead of annually (Training Alternative #4)	($510,796,039)	- 42.0%	$705,056,946
16a. Require refresher training every 2 years instead of annually (Training Alternative #4a)	($419,738,961)	-34.5%	$796,114,024
17. Employees specifically-designated to respond to workplace violence incidents (e.g. incident response team members) receive incident response training; all others receive the WPV training specified under the primary/default framework (Training Option #1)	$299,590,333	24.6%	$1,515,443,318
18. Require 24 hours of training for small facilities (≤2 employees on site) (Training Option #2)	$14,139,424	1.2%	$1,229,992,409
19. Reduction of expectation of training length for the most advanced level of employee workplace violence prevention training (Training Sensitivity Test #1)	($19,848,474)	-1.6%	$1,196,004,511
G. Violent Incident Investigation & Recordkeeping			
20. Require post-incident investigations only for workplace violence incidents involving physical assault (Incident Investigation Alternative #1)	($13,729,830)	-1.1%	$1,202,123,156
21. Require post-incident medical and psychological evaluations and treatment			
For WPV Recordable, Lost-Work Incidents (Post-incident Evaluations Options #1)	$108,746,045	8.9%	$1,324,599,030
For WPV Recordable, Non-Lost-Work Incidents (Post-incident Evaluations Options #2)	$231,641,450	19.1%	$1,447,494,435
For Total Recordable WPV Incidents (Post-incident Evaluations Options #3)	$340,387,495	28.0%	$1,556,240,480
Effective Date of the Standard Alternative #1: Extension of compliance date for requirements in paragraphs (e) Control Measures and (f) Training or any other provisions in this draft standard might require more than six month to come into compliance.			
General Alternative: OSHA opts to take no action on this draft standard on Prevention of Workplace Violence in Healthcare and Social Assistance, and continues to address workplace violence hazards in healthcare and social assistance solely through use of the General Duty Clause.			

OSHA, 2022.

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Appendix A: Methodology for Estimating Potentially Regulated Entities

This Appendix describes additional details and data underlying OSHA's industry profile of entities potentially regulated by the draft regulatory framework, including the number of entities and employees in each setting for private and public entities. Sections A.1 – A.4 present, respectively, private for-profit entities, private non-profit entities, state and local government entities, and a summary of all affected entities. Then, in Section A.5, SBA/RFA-defined small entities and very small entities are profiled for all affected industries. Finally, in Section A.6, OSHA presents a profile of direct patient/client/resident care and patient/client/resident contact employees affected by the draft regulatory framework.

A.1 For-Profit Entities

OSHA used data from the U.S. Census' 2017 County Business Patterns (CBP) to estimate the number of entities, establishments, employees, and annual revenues of for-profit entities in the potentially regulated industries. Firms, establishments, employees, and revenue were obtained by NAICS code directly from the 2017 CBP data, by employment size (CBP, 2019a; CBP, 2019b). All revenue data were then adjusted to 2019 dollars based on the Bureau of Economic Analysis implicit price deflator for GDP (BEA, 2019).

OSHA also made two adjustments to the data to separate for-profit entities from the original CBP dataset.

- **Account for government hospitals in County Business Patterns**

The Census' CBP data include some government hospitals (NAICS 622).[32] These entities are also reported separately in the CBP by-ownership data series (CBP, 2019b). OSHA removed these from the primary CBP data by subtracting from the overall totals, the reported figures for government entities, establishments, employees, and revenue, by NAICS code.[33]

- **Account for non-profit entities in County Business Patterns**

The Census' CBP data also includes non-profit entities. OSHA deducted from the total, the estimates for non-profit entities, by NAICS code, obtained from CBP's by-ownership data series.

OSHA used a specialized data source in the case of private fire departments since this specific subcategory is not present in the CBP data. OSHA relied on data from the U.S. Fire Administration's (USFA) National Fire Department Registry (USFA, 2018), which includes a profile of fire departments and related services. This sub-population of potential regulated entities is part of the health care setting identified within the scope of OSHA's Emergency Response prospective rulemaking (see SBREFA SBAR Panel Report; https://www.osha.gov/emergency-response/rulemaking).

[32] https://www.census.gov/programs-surveys/susb/technical-documentation/methodology.html

[33] The CBP data includes some government establishments in four NAICS industries: General Medical and Surgical Hospitals (622110), Psychiatric and Substance Abuse Hospitals (622210), Specialty (except Psychiatric and Substance Abuse) Hospitals (622310), Nursing Care Facilities (Skilled Nursing Facilities) (623110). For this PIRFA, OSHA assumed that the number of government entities is identical to the number of government establishments.

The USFA registry indicates that there are 15,040 private responders nationwide. Due to chronic under-reporting of these emergency specialists and the uncertainty surrounding budgetary constraints at the local governmental level, OSHA doubled its estimate for private firefighters, and for the revised total of 30,080 responders, the agency estimated that there are approximately 872 private fire response establishments. Next, OSHA estimated that 53 percent of private fire departments have staff cross-trained as EMTs, based on the percentage of all fire departments with cross-trained personnel, including both public and private. Applying this percentage to the estimate for private responders and their employers (30,080 responders, 872 employers) resulted in an estimated 461 private establishments and 16,338 private responders. The number of private firefighting entities and associated revenue were estimated based on the ratio of establishments to entities, and revenue per establishment, for the Ambulance Services NAICS code (i.e., the other component of the Emergency Responder health care setting).

Table A-1 presents summary statistics for the for-profit sector, by health care setting. It shows there are about 122,000 entities, 175,000 establishments, and 5.8 million employees in private, for-profit industries potentially affected by a proposed workplace violence standard.

Table A-1. Summary of In-Scope Industries, For-Profit

Healthcare or Social Assistance Setting	Entities	Establishments	Employees	Revenue ($2019, billions)
Behavioral Health Facilities	41,202	58,344	597,823	$47.6
Hospitals, other than mental health	4,777	8,754	948,597	$179.3
Residential Care Facilities	24,289	37,589	1,957,969	$145.4
Home Healthcare Services	39,132	52,714	1,980,102	$108.6
Social Assistance Facilities	9,828	13,744	119,947	$9.6
Emergency Responders	2,332	4,187	157,703	$14.2
Total	121,561	175,332	5,762,141	$504.8

Source: Source: OSHA, 2023, based on CBP 2019a, CBP 2019b.
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

A.2 Non-Profit Entities

OSHA used data from the CBP-by-ownership data series to estimate the number and size of non-profit establishments and employees by six-digit NAICS code, as well as the employment size classification for non-profit establishments. OSHA applied the overall firms per establishment ratio to the number of non-profit firms and the overall per-employee revenue in order to estimate revenue for non-profit establishments.[34]

[34] County Business Patterns (CBP) is an annual series published by the U.S. Census Bureau that provides subnational economic data by industry. The CBP series includes the number of establishments, employment during a given week, first quarter payroll, and annual payroll.

The 2017 CBP data include entity revenue by employment size category. OSHA uses these data to estimate the average revenue per firm, by NAICS code and employment-size category. OSHA first identifies the SBA-designated revenue threshold for each NAICS. Next, OSHA aggregates the number of firms across employment-sizes for all

Table A-2 summarizes OSHA's estimates for non-profit entities potentially affected by a workplace violence standard, which include about 68,400 entities employing approximately 7.1 million employees.

Table A-2. Summary of In-Scope Industries, Non-Profit

Healthcare Setting	Entities	Establishments	Employees	Revenue ($2019, billions)
Behavioral Health Facilities	11,460	32,549	748,537	$51.0
Hospitals, other than mental health	1,995	4,187	3,902,235	$731.2
Residential Care Facilities	6,254	9,845	760,479	$56.7
Home Healthcare Services	11,931	15,432	652,066	$32.1
Social Assistance Facilities	35,755	49,568	990,072	$95.0
Emergency Responders	995	1,787	43,441	$3.9
Total	68,391	113,368	7,096,830	$970.0

Source: OSHA, 2023, based on CBP (2019a & 2019b)
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

A.3 State and Local Government Entities

OSHA obtains estimates of the overall population of State and Local government entities from the Bureau of Labor Statistics' Quarterly Census of Employment and Wages (QCEW), 2017 annual estimates (BLS 2018). The QCEW program reports establishments and employees, including for government, at varying NAICS industry classifications and geographic levels of aggregation. Due to OSHA's delegation of jurisdictional authority to other federal entities through the OSH Act and memoranda of understanding, federal entities are not included in OSHA's analysis of the potential rule.[35] Only public entities that are in OSHA state-plan states are under OSHA's jurisdiction and therefore this analysis also *excludes* public entities in non-state-plan states.

Table A-3 presents the states that have state plans and their public entities are *included* in the analysis:

firms with average revenue below the applicable SBA revenue threshold. The result of that calculation was the number of SBA-defined small private firms by NAICS code. For this PIRFA, OSHA estimated the percentage of firms that are small for each NAICS code, and applied that percentage to the number of affected for-profit entities to estimate the number of affected small for-profit entities. To estimate the number of affected non-profit entities, OSHA applied the simplifying assumption that revenue distribution patterns among non-profit entities were identical to those among for-profit entities.

[35] Section 19, Federal Agency Safety Programs and Responsibilities, of the OSH Act states, "It shall be the responsibility of the head of each Federal agency . . . to establish and maintain an effective and comprehensive occupational safety and health program which is consistent with the standards promulgated under section 6 [of the OSH Act]." 29 U.S.C. § 668(a). Although section 19 covers all Federal employees, Executive Order 12196 directs the Secretary of Labor to cooperate and consult with the heads of agencies in the legislative and judicial branches of the government to help them adopt safety and health programs. Exec. Order No. 12196, 45 Fed. Reg. 12769 (Feb. 26, 1980).

Table A-3. State-Plan States under OSHA's Jurisdiction

Alaska	Illinois	Maryland	New Mexico	Tennessee	Wyoming
Arizona	Indiana	Michigan	New York	Utah	US Virgin Islands & Puerto Rico
California	Iowa	Minnesota	North Carolina	Vermont	
Connecticut	Kentucky	Nevada	Oregon	Virginia	
Hawaii	Maine	New Jersey	South Carolina	Washington	

Source: OSHA, 2023.

For potentially regulated public fire departments with firefighters cross-trained as EMTs, OSHA relied on estimates from USFA (USFA, 2018). OSHA excluded federal entities, public entities in non-state plan states, entities that do not report having any firefighters, and non-firefighting personnel included in the USFA registry data. Further, the analysis excluded volunteers and all-volunteer emergency service organizations in state plan states that do not cover volunteers.[36] OSHA estimates that there are 10,679 in-scope public fire departments and 493,594 associated public responders. Similar to the estimation method described above for the private sector, OSHA estimated that 53 percent of these potentially regulated departments and responders include cross-trained EMTs, resulting in a total of 5,649 public fire departments and 261,091 public responders that are in scope. In addition, 98 percent of public entities are operated by local governments versus state governments (USFA, 2018). Based on this estimate, OSHA disaggregated the in-scope public firefighter entity population into state and local government categories.

Table A-4 and Table A-5 summarize the number of estimated state and local government entities and employees, by healthcare setting that are in scope of the draft workplace violence regulatory framework. There are a total of approximately 12,000 entities and 1.1 million employees in the overall government sector estimated to be in scope.

Table A-4. Summary of In-Scope Industries, State-Government

Healthcare Setting	Entities	Employees
Behavioral Health Facilities	1,735	123,752
Hospitals, other than mental health	170	154,459
Residential Care Facilities	531	23,137
Home Healthcare Services	82	11,564
Social Assistance Facilities	1,136	55,196

[36] The state plan states that do not cover volunteers are Connecticut, Kentucky, Maryland, New Mexico, North Carolina, Tennessee, Vermont, Virginia, and Wyoming. See Preliminary Initial Regulatory Flexibility Analysis of the draft standard for Emergency Response, pp. 60-63, https://www.osha.gov/sites/default/files/er-pirfa.pdf (accessed October 17, 2021).

Healthcare Setting	Entities	Employees
Emergency Responders	104	4,821
Total	3,759	372,930

Source: OSHA, 2023, based on BLS (2018) and USFA (2018).
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

Table A-5. Summary of In-Scope Industries, Local-Government

Healthcare Setting	Entities	Employees
Behavioral Health Facilities	272	13,319
Hospitals, other than mental health	755	374,338
Residential Care Facilities	166	21,053
Home Healthcare Services	428	15,716
Social Assistance Facilities	664	36,017
Emergency Responders	5,704	260,482
Total	7,988	720,926

Source: OSHA, 2023, based on BLS (2018) and USFA (2018).
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

A.4 Summary of All Potentially-Regulated Entities

In total, OSHA estimates there are approximately 201,700 entities employing 14 million people within the scope of the regulatory framework, as summarized in Table A-6.

Table A-6. Summary of Potentially Regulated Entities

Healthcare Setting	Behavioral Health Facilities	Hospitals, other than mental health	Residential Care Facilities	Home Healthcare Services	Social Assistance	Emergency Responders	Total
For profit							
Entities	41,202	4,777	24,289	39,132	9,828	2,332	121,561
Establishments	58,344	8,754	37,589	52,714	13,744	4,187	175,332
Employees	597,823	948,597	1,957,969	1,980,102	119,947	157,703	5,762,141
Non-Profit							
Entities	11,460	1,995	6,254	11,931	35,755	995	68,391
Establishments	32,549	4,187	9,845	15,432	49,568	1,787	113,368
Employees	748,537	3,902,235	760,479	652,066	990,072	43,441	7,096,830
State and Local Government							
Entities	2,007	925	697	510	1,799	5,808	11,747
Establishments	2,007	925	697	510	1,799	5,808	11,747
Employees	137,072	528,797	44,190	27,281	91,213	265,303	1,093,856

Healthcare Setting	Behavioral Health Facilities	Hospitals, other than mental health	Residential Care Facilities	Home Healthcare Services	Social Assistance	Emergency Responders	Total
Total							
Entities	54,670	7,697	31,240	51,573	47,382	9,136	201,698
Establishments	92,900	13,866	48,131	68,656	65,111	11,782	300,447
Employees	1,483,432	5,379,629	2,762,638	2,659,449	1,201,232	466,447	13,952,827

Source: OSHA, 2023, based on CBP (2019a & 2019b), BLS (2018), USFA (2018).
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

A.5 Small and Very Small Potentially-Regulated Entities

Private Entities

The 2017 CBP data includes entity revenue by employment size category.[37] OSHA uses these data to estimate the average revenue per firm, by NAICS code and employment-size category. OSHA aggregates the number of firms across employment-sizes for all firms with average revenue below the applicable SBA revenue threshold. This results in the number of SBA-defined small private firms by NAICS code. OSHA estimates the percentage of firms that are small for each NAICS code, and applies that percentage to the number of for-profit entities to estimate the number of for-profit, small entities. OSHA uses this approach because the CBP data do not provide data on revenue by ownership category. OSHA uses the same approach to estimate the number of establishments and employees for small entities from the 2017 CBP Statistics of U.S. Businesses data. For very small entities, those with fewer than 20 employees, OSHA relies directly on the 2017 CBP data with its employment size categories.

Table A-7 presents the resulting number of entities, establishments, and employees associated with small and very small for-profit entities estimated to be in scope of the draft regulatory framework and therefore included in the analysis.

Table A-7. For-Profit, In-Scope, Small and Very Small Entities

Healthcare Setting	SBA-Defined Small Entities	Very Small Entities (Fewer than 20 Employees)
Firms		
Behavioral Health Facilities	40,587	36,528
Hospitals, other than mental health	3,908	2,441
Residential Care Facilities	23,077	13,196
Home Healthcare Services	37,913	24,753
Social Assistance Facilities	9,539	8,291
Emergency Responders	2,392	1,165
Total	117,416	86,375

[37] The employment size categories are: entities with 4 employees or less; 5-9 employees; 10-19 employees; 20-99 employees; 100-499 employees; and 500 or more employees.

Healthcare Setting	SBA-Defined Small Entities	Very Small Entities (Fewer than 20 Employees)
Establishments		
Behavioral Health Facilities	48,900	36,760
Hospitals, other than mental health	4,182	2,453
Residential Care Facilities	25,419	13,296
Home Healthcare Services	42,077	24,824
Social Assistance Facilities	11,952	8,366
Emergency Responders	2,898	1,177
Total	135,427	86,878
Employees		
Behavioral Health Facilities	355,968	87,946
Hospitals, other than mental health	96,015	17,066
Residential Care Facilities	933,167	67,446
Home Healthcare Services	1,088,009	108,191
Social Assistance Facilities	83,293	22,398
Emergency Responders	92,761	8,993
Total	2,649,212	312,040

Source: OSHA, 2023, based on CBP (2019a, 2019b)
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

OSHA estimates the number of non-profits that are very small by assuming the same proportion are very small as in the combined for-profit and non-profit entity data. Table A-8 presents RFA-defined small and very small non-profit entities. RFA-defined small non-profit statistics are the same as total non-profit statistics.

Table A-8. Non-Profit, In-Scope, Small and Very Small Entities

Healthcare Setting	RFA-Defined Small Entities	Very Small Entities (Less than 20 Employees)
Firms		
Behavioral Health Facilities	11,460	6,362
Other Hospitals	1,995	278
Residential Care Facilities	6,254	2,670
Home Healthcare Services	11,931	7,254
Social Assistance Facilities	35,755	24,981
Emergency Responders	995	531
Total	68,391	42,075
Establishments		
Behavioral Health Facilities	32,549	6,452
Other Hospitals	4,187	282
Residential Care Facilities	9,845	2,693
Home Healthcare Services	15,432	7,279

Healthcare Setting	RFA-Defined Small Entities	Very Small Entities (Less than 20 Employees)
Social Assistance Facilities	49,568	25,200
Emergency Responders	1,787	537
Total	113,368	42,441
Employees		
Behavioral Health Facilities	748,537	39,097
Other Hospitals	3,902,235	1,728
Residential Care Facilities	760,479	18,212
Home Healthcare Services	652,066	42,144
Social Assistance Facilities	990,072	128,654
Emergency Responders	43,441	4,959
Total	7,096,830	234,794

Source: OSHA, 2023, based on CBP (2019a and 2019b).
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

Public Entities

Consistent with RFA and SBA guidance, a small governmental jurisdiction is a city, county, town, township, village, school district, or special district with a population of less than 50,000.[38] Small, public entities within the scope of the draft regulatory framework include entities associated with local governments, where the local government serves a population of less than 50,000.

OSHA obtains estimates of state and local government entities from the BLS QCEW (BLS 2018). The QCEW includes detailed 6-digit NAICS industry data at the national level for state and local government. To estimate the subset of local government entities that are small, OSHA used additional QCEW data that were specified geographically by county and are available at the 4-digit NAICS industry level, along with 2017 county-level population data from the Census' American Community Survey (ACS 2018). Using these data, OSHA estimated the percentage of local government entities—looking at county-level entities—that serve small counties (i.e., with a population of less than 50,000), for each affected healthcare setting. OSHA then applied these proportions to the national estimates of all local government entities, by industry, to estimate the subset that are small. To estimate the number of employees in these small local government entities, OSHA assumed small entity employment is proportional to the percentage of employees in small entities based on the original CBP data which includes a blend of for-profit, non-profit, and public hospitals.

For in-scope fire departments and cross-trained EMT personnel, the available data on small governmental jurisdictions does not allow OSHA to identify the number of fire departments that serve small governments. In order to derive these estimates, OSHA first obtained an estimate of the overall number of people served per employee from Firehouse Magazine (2018) survey data.[39] This survey found that each firefighter serves an average of 647 people. Based on this, OSHA estimated that fire departments with up to 77 employees could serve populations of

[38] *See* 5 U.S.C. § 601(5).
[39] Part one of Firehouse Magazine's (2018) 2017 National Run Survey presents data from a survey of 259 fire departments, which has statistics about population served and staffing.

50,000 people (50,000/647 = 77).

Taking all departments in the U.S. Fire Administration's (USFA, 2018) registry data with 77 or fewer employees then gives an estimate of how many departments serve populations of fewer than 50,000.

Table A-9 gives summary statistics by healthcare setting for small and very small government entities.

Table A-9. Local Government In-Scope, Small and Very Small Entities

Healthcare Setting	RFA-Defined Small Entities		Very Small Entities (Less than 20 Employees)	
	Entities	Employees	Entities	Employees
Behavioral Health Facilities	127	2,491	44	216
Other Hospitals	374	70,202	28	92
Residential Care Facilities	103	7,069	31	153
Home Healthcare Services	175	4,582	101	456
Social Assistance Facilities	321	4,191	188	819
Emergency Responders	5,109	146,797	948	11,253
Total	6,210	235,333	1,338	12,987

Source: OSHA, 2023, based on BLS (2018), ACS (2019).
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

Table A-10 presents a summary profile of SBA/RFA-defined small and very small entities affected by the draft regulatory framework.

Table A-10. Summary of Small Entities within the In-Scope Health Care and Social Assistance Industry

Private, For Profit

Healthcare Setting	SBA-Defined Small Entities			Very Small Entities		
	Entities	Establishments	Employees	Entities	Establishments	Employees
Behavioral Health	40,587	48,900	355,968	36,528	36,760	87,946
Other Hospitals (excluding BH)	3,908	4,182	96,015	2,441	2,453	17,066
Residential Care Facilities	23,077	25,419	933,167	13,196	13,296	67,446
Home Healthcare Services	37,913	42,077	1,088,009	24,753	24,824	108,191
Social Assistance	9,539	11,952	83,293	8,291	8,366	22,398
Emergency Responders	2,392	2,898	92,761	1,165	1,177	8,993
Total	117,416	135,427	2,649,212	86,375	86,878	312,040

Table A-10, continued. Summary of Small Entities In-Scope Health Care and Social Assistance Industry

Private, Non-Profit

Healthcare Setting	RFA-Defined Small Entities (All Non-Profits)			Very Small Entities		
	Entities	Establishments	Employees	Entities	Establishments	Employees
Behavioral Health	11,460	32,549	748,537	6,362	6,452	39,097
Other Hospitals (excluding BH)	1,995	4,187	3,902,235	278	282	1,728
Residential Care Facilities	6,254	9,845	760,479	2,670	2,693	18,212
Home Healthcare Services	11,931	15,432	652,066	7,254	7,279	42,144
Social Assistance	35,755	49,568	990,072	24,981	25,200	128,654
Emergency Responders	995	1,787	43,441	531	537	4,959
Total	68,391	113,368	7,096,830	42,075	42,441	234,794

Table A-10, continued. Summary of Small Entities In-Scope Health Care and Social Assistance Industry

Public, State

Healthcare Setting	RFA-Defined Small Entities			Very Small Entities		
	Entities	Establishments	Employees	Entities	Establishments	Employees
Behavioral Health		0	0		133	2,043
Other Hospitals (excluding BH)		0	0		4	11
Residential Care Facilities		0	0		216	1,065
Home Healthcare Services		0	0		41	714
Social Assistance		0	0		514	7,991
Emergency Responders		0	0		17	205
Total		0	0		923	12,029

Table A-10, continued. Summary of Small Entities In-Scope Health Care and Social Assistance Industry

Public, Local

Healthcare Setting	RFA-Defined Small Entities			Very Small Entities		
	Entities	Establishments	Employees	Entities	Establishments	Employees
Behavioral Health		127	2,491		44	216
Other Hospitals (excluding BH)		374	70,202		28	92
Residential Care Facilities		103	7,069		31	153
Home Healthcare Services		175	4,582		101	456
Social Assistance		321	4,191		188	819
Emergency Responders		5,109	146,797		948	11,253
Total		6,210	235,333		1,338	12,987

Table A-10, continued. Summary of Small Entities In-Scope Health Care and Social Assistance Industry

All Small Entities

Healthcare Setting	SBA/RFA-Defined Small Entities			Very Small Entities		
	Entities	Establishments	Employees	Entities	Establishments	Employees
Behavioral Health	52,047	81,576	1,106,995	42,890	43,389	129,301
Other Hospitals (excluding BH)	5,903	8,743	4,068,452	2,719	2,766	18,897
Residential Care Facilities	29,331	35,367	1,700,716	15,866	16,235	86,876
Home Healthcare Services	49,844	57,684	1,744,657	32,007	32,245	151,505
Social Assistance	45,293	61,841	1,077,556	33,272	34,267	159,861
Emergency Responders	3,388	9,794	282,999	1,696	2,678	25,409
Total	185,806	255,005	9,981,375	128,449	131,580	571,849

Source: OSHA, 2023.
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

Appendix B: Direct Patient/Client/Resident Care and Contact Occupations

Table B-1, Table B-2, and Table B-3 below list direct patient/client/resident care and patient contact occupations, and supervisory staff occupations, as identified by OSHA, in the BLS Occupational Employment Statistics data (BLS, 2019).

Table B-1. Direct Patient/Client/Resident Care Occupations

BLS Occupation Code, detailed	Occupation[40]
19-3031	Clinical, Counseling, and School Psychologists
19-3039	Psychologists, All Other
21-1015	Rehabilitation Counselors
21-1018	Substance Abuse, Behavioral Disorder, and Mental Health Counselors
21-1019	Counselors, All Other
21-1021	Child, Family, and School Social Workers
21-1022	Healthcare Social Workers
21-1023	Mental Health and Substance Abuse Social Workers
21-1029	Social Workers, All Other
21-1093	Social and Human Service Assistants
21-1094	Community Health Workers
21-1099	Community and Social Service Specialists, All Other
29-1011	Chiropractors
29-1021	Dentists, General
29-1022	Oral and Maxillofacial Surgeons
29-1023	Orthodontists
29-1024	Prosthodontists
29-1029	Dentists, All Other Specialists
29-1041	Optometrists
29-1061	Anesthesiologists
29-1062	Family and General Practitioners
29-1063	Internists, General

[40] Some of the occupations on this list may not typically work in a setting covered by this draft rule. For example, massage therapists do not typically work in settings covered by the draft rule and most will not be covered. However, when they work in a workplace that is covered by the draft rule (e.g., a hospital), they will be covered. See OSHA, 2022 [Excel workbook], tab "BLS OES 2018", for the profile of affected BLS occupation codes.

Table B-2, continued. Direct Patient/Client/Resident Care Occupations

BLS Occupation Code, detailed	Occupation
29-1064	Obstetricians and Gynecologists
29-1065	Pediatricians, General
29-1066	Psychiatrists
29-1067	Surgeons
29-1069	Physicians and Surgeons, All Other
29-1071	Physician Assistants
29-1081	Podiatrists
29-1122	Occupational Therapists
29-1123	Physical Therapists
29-1124	Radiation Therapists
29-1125	Recreational Therapists
29-1126	Respiratory Therapists
29-1127	Speech-Language Pathologists
29-1128	Exercise Physiologists
29-1129	Therapists, All Other
29-1141	Registered Nurses
29-1151	Nurse Anesthetists
29-1161	Nurse Midwives
29-1171	Nurse Practitioners
29-1181	Audiologists
29-1199	Health Diagnosing and Treating Practitioners, All Other
29-2021	Dental Hygienists
29-2031	Cardiovascular Technologists and Technicians
29-2032	Diagnostic Medical Sonographers
29-2033	Nuclear Medicine Technologists
29-2034	Radiologic Technologists
29-2035	Magnetic Resonance Imaging Technologists
29-2041	Emergency Medical Technicians and Paramedics
29-2051	Dietetic Technicians
29-2053	Psychiatric Technicians
29-2054	Respiratory Therapy Technicians
29-2055	Surgical Technologists
29-2057	Ophthalmic Medical Technicians
29-2061	Licensed Practical and Licensed Vocational Nurses
29-2081	Opticians, Dispensing
29-2091	Orthotists and Prosthetists
29-2092	Hearing Aid Specialists
29-2099	Health Technologists and Technicians, All Other
29-9092	Genetic Counselors

Table B-2, continued. Direct Patient/Client/Resident Care Occupations

BLS Occupation Code, detailed	Occupation
29-9099	Healthcare Practitioners and Technical Workers, All Other
31-1011	Home Health Aides
31-1013	Psychiatric Aides
31-1014	Nursing Assistants
31-1015	Patient Care Assistants
31-2011	Occupational Therapy Assistants
31-2012	Occupational Therapy Aides
31-2021	Physical Therapist Assistants
31-2022	Physical Therapist Aides
31-9011	Massage Therapists
31-9091	Dental Assistants
31-9092	Medical Assistants
31-9097	Phlebotomists
31-9099	Healthcare Support Workers, All Other
33-2011	Firefighters
33-3012	Correctional Officers and Jailers
39-9021	Personal Care Aides
39-9099	Personal Care and Service Workers, All Other
53-3011	Ambulance Drivers and Attendants, Except Emergency Medical Technicians

Source: OSHA, 2023.

Table B-3 Direct Patient/Client/Resident Contact Occupations

BLS Occupation Code, detailed	Occupation
33-9032	Security Guards
33-9099	Protective Service Workers, All Other
35-2012	Cooks, Institution and Cafeteria
35-2021	Food Preparation Workers
35-3041	Food Servers, Non-restaurant
35-9011	Dining Room and Cafeteria Attendants and Bartender Helpers
37-2011	Janitors and Cleaners, Except Maids and Housekeeping Cleaners
37-2012	Maids and Housekeeping Cleaners
37-2019	Building Cleaning Workers, All Other
39-9041	Residential Advisors

Source: OSHA, 2023.

Table B-4 Supervisory Occupations

BLS Occupation Code	Occupation	Patient Care Supervisor	Patient Contact Supervisor
11-1021	General and Operations Managers	X	
11-9111	Medical and Health Services Managers	X	
11-9161	Emergency Management Directors	X	
11-9199	Managers, All Other	X	
11-9051	Food Service Managers		X
11-9151	Social and Community Service Managers	X	
35-1012	First-Line Supervisors of Food Preparation and Serving Workers		X
37-1011	First-Line Supervisors of Housekeeping and Janitorial Workers		X
37-1012	First-Line Supervisors of Landscaping, Lawn Service, and Grounds-keeping Workers		X
39-1021	First-Line Supervisors of Personal Service Workers	X	

Source: OSHA, 2023.

Appendix C: Workplace Violence Incident Analysis

C.1 Introduction

OSHA developed estimates of workplace violence incidents to support the analysis of costs and benefits associated with the regulatory framework. Workplace violence incidents were a key input for several parts of the analysis, including:

- Estimating costs for incident-related hazard assessments, as well as for incident-related reporting and investigation under paragraphs (d)(4)(i) and (g); and,
- Estimating the baseline risk, including the baseline number of WPV incidents and the baseline incidence rate.

The incident analysis identified four types of WPV incidents, partly reflecting availability of data as well as the regulatory framework's definition of a WPV incident that includes threat of physical assault:

- **Recordable, Lost-Workday**
- **Recordable, Non-Lost-Workday (more than first-aid)**
- **Other Physical (up to first-aid)**
- **Threats**

Recordable incidents are all cases in the BLS' Survey of Occupational Injuries and Illnesses (SOII), which in turn are based on OSHA 300 logs of workplace incidents whose severity require more than first aid. (BLS 2021). Lost-work day injuries are a subset of recordable injuries, where the incident leads to days away from work for the injured person. Other (lesser) physical incidents that would be incidents under the definitions of this regulatory framework are not recorded and not part of SOII data. Similarly, threats are not recorded in OSHA 300 logs but are covered under this regulatory framework. OSHA estimates the number of each type of incident based primarily on incident data published by BLS, and extrapolations based on this data. For the purposes of costing, OSHA conservatively does not account for the potential effect of the potential rule in reducing WPV incidents. In other words, the cost analysis of the draft regulatory framework assumes the same number of incidents that occur currently, in the absence of an OSHA rule.

All incident estimates presented below are developed at the NAICS industry-ownership-size level.

C.2 WPV Lost Workday Injuries and Illnesses

Lost-work day injuries in the private sector are obtained from the BLS' 2019 SOII incident statistics giving the number, incidence rate, and median days away from work associated with different types of occupational injuries and illnesses (BLS 2021). These data are specified primarily at the 4-digit NAICS industry level.

OSHA's methodology is the following. First, the agency estimated incidence rates for each NAICS industry based on the 4-digit NAICS industry sectors for which rates were available. Incidence rates given in the SOII are in units of incidents-per-10,000 full time equivalent (FTE)

worker, where an FTE employee works 40 hours per week for 50 weeks per year. Data on lost-work time injuries include more detailed information about the circumstances involved than other kinds of injuries, including a coding of event type. Incidence rates are included for two event types of WPV lost-work day incidents in the SOII data: *Intentional injury by other person*; and, *Injury by person-unintentional or intent unknown.* With respect to unintentional injuries, OSHA was specifically interested in a subset of that category, namely, *Injured by physical contact with person while restraining- subduing—unintentional.*

To estimate state and local government incidence rates, OSHA applied additional assumptions. The more detailed SOII 2019 data with event type include state and local government incidence rates for only two NAICS industries: general hospitals, and nursing care facilities. OSHA began with these state and local rates and then estimated state and local rates for other NAICS industries based on the relationship between public and private rates for general hospitals, and the private rates for all other NAICS industries. [41] Table C-1 through Table C-3 present lost-workday incidence rates, per 10,000 FTE employees, estimated from the BLS data, for private, state, and local government facilities, by industry.

[41] OSHA used the public General Hospital and Nursing Care facility rates directly for those two NAICS industries. For other NAICS industry X, Public rate_X = Private_rate_X * (Public_rate_Hospital / Private_rate_Hospital). This adjustment assumes that whatever systemic factors drive the difference in public/private rates of violence incidents in hospitals (differences in facilities, population mix, etc.) also proportionately affect rates in the other affected industries. The ratio of State government-to-private in General Hospitals is 11 for intentional injuries; for Local government-to-private the ratio is 1.6. The ratios applied to Nursing Homes, the other possible choice for this adjustment, are identical to those for general hospitals.

Table C-1. Private Lost Workday Incidence Rates (incidents per 10,000 FTEs)

NAICS	NAICS Description	Intentional Injury by Other Person	Injured by physical contact while restraining--unintentional	Total WPV Lost-Work Day Rate
621112	Offices of Physicians, Mental Health Specialists	26.6	0.0	26.6
621300	Offices of other health practitioners	10.5	2.6	13.1
621420	Outpatient Mental Health and Substance Abuse	3.9	0.4	4.3
621493	Freestanding Ambulatory Surgical, Emergency	3.9	0.4	4.3
621610	Home Health Care Services	4.1	-	4.1
621910	Ambulance Services	3.4	2.2	5.6
622110	General Medical and Surgical Hospitals	9.7	2.4	12.1
622210	Psychiatric and Substance Abuse Hospitals	124.9	42.8	167.7
622310	Specialty Hospitals (excl. Psychiatric, Substance)	12.8	3.9	16.7
623110	Nursing Care Facilities (Skilled Nursing Facilities)	14.9	0.3	15.2
623210	Residential Intellectual, Developmental Disability	41.7	11.5	53.2
623220	Residential Mental Health and Substance Abuse	41.7	11.5	53.2
623311	Continuing Care Retirement Communities	8.5	0.7	9.2
623312	Assisted Living Facilities for the Elderly	8.5	0.7	9.2
623990	Other Residential Care Facilities	61	29	90.0
624110	Child and Youth Services	29.2	6.9	36.1
624120	Services for Elderly and Persons with Disabilities	14.7	0.5	15.2
624190	Other Individual and Family Services	7.6	1.1	8.7
624210	Community Food Services	7.5	-	7.5
624221	Temporary Shelters	11.8	-	11.80
624229	Other Community Housing Services	11.8	-	11.80
624230	Emergency and Other Relief Services	7.5	-	7.50
624310	Vocational Rehabilitation Services	17	1.7	18.70
	Firefighter-EMTs	2	1.3	3.3

Source: OSHA, 2023, based on BLS (2021).
Note: A "-" means the statistic does not meet BLS standards for publication (see https://www.bls.gov/opub/hom/soii/presentation.htm, Publication guidelines for SOII estimates. OSHA assigned these case rates a value of zero.

Table C-2. State Government Lost Workday Incidence Rates (incidents per 10,000 FTEs)

NAICS	NAICS Description	Intentional Injury by Other Person	Injured by physical contact while restraining--unintentional	Total WPV Lost-Work Day Rate
621112	Offices of Physicians, Mental Health Specialists	9	5	13
621330	Offices of Mental Health Practitioners	34	5	38
621420	Outpatient Mental Health and Substance Abuse	42	9	52
621493	Freestanding Ambulatory Surgical, Emergency	42	9	52
621610	Home Health Care Services	45	-	45
621910	Ambulance Services	37	51	88
622110	General Medical and Surgical Hospitals	105	55	161
622210	Psychiatric and Substance Abuse Hospitals	1,357	984	2,342
622310	Specialty Hospitals (excl. Psychiatric, Substance)	139	90	229
623110	Nursing Care Facilities (Skilled Nursing Facilities)	136	52	189
623210	Residential Intellectual, Developmental Disability	453	265	718
623220	Residential Mental Health and Substance Abuse	453	265	718
623311	Continuing Care Retirement Communities	92	16	108
623312	Assisted Living Facilities for the Elderly	92	16	108
623990	Other Residential Care Facilities	663	667	1,330
624110	Child and Youth Services	317	159	476
624120	Services for Elderly and Persons with Disabilities	160	12	171
624190	Other Individual and Family Services	83	25	108
624210	Community Food Services	81	-	81
624221	Temporary Shelters	128	-	128
624229	Other Community Housing Services	128	-	128
624230	Emergency and Other Relief Services	81	-	81
624310	Vocational Rehabilitation Services	185	39	224
	Firefighter-EMTs	22	30	52

Source: OSHA, 2023, based on BLS (2020-2021).
Note: A "-" means the statistic does not meet BLS standards for publication (see https://www.bls.gov/opub/hom/soii/presentation.htm, Publication guidelines for SOII estimates). OSHA assigned these case rates a value of zero.

Table C-3. Local Government Lost Workday Incidence Rates (incidents per 10,000 FTEs)

NAICS	NAICS Description	Intentional Injury by Other Person	Injured by physical contact while restraining--unintentional	Total WPV Lost-Work Day Rate
621112	Offices of Physicians, Mental Health Specialists	1.2	0.2	1
621330	Offices of Mental Health Practitioners	4.8	0.2	5
621420	Outpatient Mental Health and Substance Abuse	6.1	0.5	7
621493	Freestanding Ambulatory Surgical, Emergency	6.1	0.5	7
621610	Home Health Care Services	6.4	-	6
621910	Ambulance Services	5.3	2.6	8
622110	General Medical and Surgical Hospitals	15	3	18
622210	Psychiatric and Substance Abuse Hospitals	194.4	49.9	244
622310	Specialty Hospitals (excl. Psychiatric, Substance)	19.9	4.6	24
623110	Nursing Care Facilities (Skilled Nursing Facilities)	31	0.4	31
623210	Residential Intellectual, Developmental Disability	64.9	13.4	78
623220	Residential Mental Health and Substance Abuse	64.9	13.4	78
623311	Continuing Care Retirement Communities	13.2	0.8	14
623312	Assisted Living Facilities for the Elderly	13.2	0.8	14
623990	Other Residential Care Facilities	95.0	33.8	129
624110	Child and Youth Services	45.5	8.1	54
624120	Services for Elderly and Persons with Disabilities	22.9	0.6	23
624190	Other Individual and Family Services	11.8	1.3	13
624210	Community Food Services	11.7	-	12
624221	Temporary Shelters	18.4	-	18
624229	Other Community Housing Services	18.4	-	18
624230	Emergency and Other Relief Services	11.7	-	12
624310	Vocational Rehabilitation Services	26.5	2.0	28
	Firefighter-EMTs	3.1	1.5	5

Source: OSHA, 2023, based on BLS (2021).
Note: A "-" means the statistic does not meet BLS standards for publication (see https://www.bls.gov/opub/hom/soii/presentation.htm, Publication guidelines for SOII estimates. OSHA assigned these case rates a value of zero.

Next, OSHA multiplied these rates by the number of potentially regulated employees, by ownership and NAICS, to estimate the number of recorded lost workday WPV incidents. This step also required accounting for the fact that not every employee in the industry profile is a full-time employee, as is used in the SOII definition of the incidence rates. OSHA obtained data describing the average hours worked per week for employees from BLS' Current Employment Statistics survey (BLS 2020b), by NAICS code for 2015 to 2018. These data indicate that employees overall work an average of between 27.0 – 38.4 hours per week, as shown in Table C-4. When applying BLS incidence rates per 10,000 FTE employees, OSHA estimated the number of FTE-equivalent employees by multiplying the number of covered employees by the percentages presented in Table C-4.

Table C-4. Number of Reported Average Hours Worked per Employee per Week

NAICS	NAICS Description	Per Employee Hours Worked	Ratio to FTE (40 hours)
621112	Offices of Physicians, Mental Health Specialists	30.6	77%
621330	Offices of Mental Health Practitioners (except Physicians)	27	68%
621420	Outpatient Mental Health and Substance Abuse Centers	34.2	86%
621493	Freestanding Ambulatory Surgical and Emergency Centers	31.2	78%
621610	Home Health Care Services	28.5	71%
621910	Ambulance Services	36.2	91%
622110	General Medical and Surgical Hospitals	37.5	94%
622210	Psychiatric and Substance Abuse Hospitals	34.8	87%
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	34.6	87%
623110	Nursing Care Facilities (Skilled Nursing Facilities)	33	83%
623210	Residential Intellectual and Developmental Disability Facilities	34.6	87%
623220	Residential Mental Health and Substance Abuse Facilities	35.3	88%
623311	Continuing Care Retirement Communities	32.4	81%
623312	Assisted Living Facilities for the Elderly	33.2	83%
623990	Other Residential Care Facilities	35.4	89%
624110	Child and Youth Services	32.1	80%
624120	Services for the Elderly and Persons with Disabilities	28.4	71%
624190	Other Individual and Family Services	32.3	81%
624210	Community Food Services	35.5	89%
624221	Temporary Shelters	33.6	84%
624229	Other Community Housing Services	33.6	84%
624230	Emergency and Other Relief Services	34	85%
624310	Vocational Rehabilitation Services	30.9	77%
561990	Fire Protection	36.2	91%

Source: OSHA, 2023, based on BLS (2020b).

As discussed in the Why Regulation is Being Considered section, numerous studies suggest that WPV incidents are under-reported in the healthcare sector. To correct for this error, OSHA assumed that *recorded* lost workday incidents represent 85 percent of all potentially recordable lost-work day incidents, including unreported incidents. This eighty-five percent estimate is based on agency judgment and may be inaccurate. This adjustment increases incidents by eighteen percent ((reported incidents / 0.85) = 1.18 * reported incidents). Based on this adjustment, the incidence rates, covered employees, and the FTE adjustment, OSHA estimated the resulting number of lost-workday WPV incidents, by NAICS, ownership, and facility size, shown by size and setting in Table C-6, below.

C.3 Recordable Non-Lost Workday Injuries, and Other WPV Incidents

Next, OSHA estimated the number of **recordable, non-lost-workday** WPV injuries. As stated above, for recorded injuries with no lost work days, the SOII does not give detailed information on the incident, including whether or not it was due to WPV. From the data, the share of lost-workday WPV incidents among all lost-workday incidents can be calculated. Assuming this same WPV share holds for recordable non-lost-workday injuries, which implies the same share for the total combining the two, OSHA derived an estimate based on the following:

- OSHA obtained BLS incidence rates for total recordable and total lost-workday, nonfatal occupational injuries and illnesses (BLS 2021), by NAICS code.

- These incidence rates were used to calculate the ratio of *total recordable* to *total lost-work day* incidents, as shown in Table C-5.

Table C-5. BLS Ratio of Total Recordable to Lost-Work Incidents

NAICS	NAICS Description	Ratio of Total Recordable to Total Lost-Work Incidents
621112	Offices of Physicians, Mental Health Specialists	3.19
621330	Offices of Mental Health Practitioners	4.56
621420	Outpatient Mental Health and Substance Abuse	4.84
621493	Freestanding Ambulatory Surgical, Emergency	4.84
621610	Home Health Care Services	2.39
621910	Ambulance Services	2.63
622110	General Medical and Surgical Hospitals	4.18
622210	Psychiatric and Substance Abuse Hospitals	2.68
622310	Specialty Hospitals (excl. Psychiatric, Substance)	2.96
623110	Nursing Care Facilities (Skilled Nursing Facilities)	3.30
623210	Residential Intellectual, Developmental Disability	3.24
623220	Residential Mental Health and Substance Abuse	3.24
623311	Continuing Care Retirement Communities	3.78
623312	Assisted Living Facilities for the Elderly	3.78
623990	Other Residential Care Facilities	2.90
624110	Child and Youth Services	2.97
624120	Services for Elderly and Persons with Disabilities	2.51
624190	Other Individual and Family Services	2.86
624210	Community Food Services	3.30
624221	Temporary Shelters	2.95
624229	Other Community Housing Services	2.95
624230	Emergency and Other Relief Services	3.30
624310	Vocational Rehabilitation Services	3.15
	Firefighter-EMTs	2.99

Source: BLS (2021).

The total recordable WPV incidents comprise those resulting in lost-work days and those not resulting in lost-work days (or non-lost-workday incidents). The ratio of total recordable WPV

incidents to recordable lost-work day incidents, presented in Table C-5, is total recordable WPV incidents divided by lost-work day incidents. Total recordable WPV incidents per NAICS industry is the number of recordable lost-work day incidents multiplied by that ratio. Recordable non-lost-workday incidents can then be calculated as the total recordable WPV incidents minus the recordable lost-work day incidents. See Appendix C Addendum for an example of how OSHA derived these estimates.

Next, OSHA, based on professional judgment, estimated that the number of incidents of other physical injuries and threats covered by the draft rule is equal to 150 percent of total recordable WPV incidents. Less severe injuries, not required to be reported on OSHA logs, may occur frequently and yet receive less attention and formal reporting. Hence, OSHA included this category of incidents in the baseline risk profile.

C.4 Total WPV Incidents and Incidents-per-Facility

Table C-6 presents OSHA's estimates of the number of WPV incidents at establishments in scope of the draft regulatory framework, annually, by healthcare setting and size. As shown in the addendum to this appendix, Step 10, OSHA summed WPV recordable lost-work day incidents and WPV recordable non-lost-work day incidents to estimate total WPV recordable incidents. To account for the underreporting of WPV incidents, OSHA estimated that the number of other WPV physical incidents and other WPV threat incidents are each one and one-half times the number of total WPV recordable incidents. The figures calculated through that methodology were then summed across NAICS industries, by entity size, to estimate the total recordable incidents and non-recordable incidents (other physical threats, and other threat incidents), by healthcare setting, shown in Table C-6.

OSHA estimates approximately 150,000 total recordable incidents per year and an overall total of 600,000 cases when non-recordable incidents are included.

Table C-6. WPV Incidents per Year, by Healthcare Setting and Facility Size

Setting and Size	WPV Recordable, Lost-Work Incidents	WPV Recordable, Non-Lost-Work Incidents	Total Recordable WPV Incidents	Other Physical Incidents	Other Threat Incidents	Total WPV Incidents (recordable and non-recordable)
All Settings	49,440	105,312	154,752	238,128	223,128	619,008
Large	41,151	87,695	128,846	193,269	193,269	515,384
Small	8,289	17,618	25,906	38,859	38,859	103,624
Very Small	1,191	2,453	3,644	5,466	5,466	14,576
Behavioral Health	28,079	51,986	80,066	120,099	120,099	320,263
Large	25,235	45,721	70,957	106,435	106,435	283,826
Small	2,844	6,265	9,109	13,664	13,664	36,437
Very Small	353	819	1,171	1,757	1,757	4,685
Other Hospitals (excluding BH)	10,051	30,662	40,714	61,071	61,071	162,855
Large	9,582	29,189	38,772	58,157	58,157	155,086

Setting and Size	WPV Recordable, Lost-Work Incidents	WPV Recordable, Non-Lost-Work Incidents	Total Recordable WPV Incidents	Other Physical Incidents	Other Threat Incidents	Total WPV Incidents (recordable and non-recordable)
Small	469	1,473	1,942	2,913	2,913	7,769
Very Small	8	30	38	57	57	152
Residential Care Facilities	5,799	12,884	18,683	28,024	28,024	74,732
Large	3,412	7,517	10,929	16,394	16,394	43,716
Small	2,386	5,368	7,754	11,631	11,631	31,015
Very Small	283	599	882	1,323	1,323	3,528
Social Assistance	3,001	5,964	8,965	13,448	13,448	35,861
Large	1,781	3,531	5,313	7,969	7,969	21,250
Small	1,220	2,432	3,653	5,479	5,479	14,610
Very Small	400	781	1,181	1,771	1,771	4,723
Home Healthcare Services	2,242	3,325	5,567	8,350	8,350	22,268
Large	1,006	1,489	2,495	3,743	3,743	9,982
Small	1,236	1,836	3,071	4,607	4,607	12,286
Very Small	133	198	332	498	498	1,327
Emergency Responders	267	491	757	1,136	1,136	3,030
Large	133	247	381	571	571	1,523
Small	133	243	377	565	565	1,507
Very Small	14	26	40	60	60	161

Source: OSHA, 2023, based on BLS (2021) and BLS (2020b).
Note: Very Small is a subset of SBA-defined Small.

Tables C-7 through C-9 summarize average annual number of WPV incidents per facility, for large, small, and very small facilities, respectively. The values presented here are aggregated on a facility-weighted basis across all ownership categories for presentation, but the analysis itself uses separate estimates by ownership.

Table C-7. WPV Incidents per Facility, Large Facilities, all Ownerships

NAICS	NAICS Description	Recordable WPV Incidents		Non-Recordable WPV Incidents		Total Incidents per Facility
		Lost-Work	Non-Lost-Work	Other Physical	Other Threats	
621112	Offices of Physicians, Mental Health Specialists	0.01	0.03	0.07	0.07	0.19
621330	Offices of Mental Health Practitioners (excl. Physicians)	0.02	0.08	0.15	0.15	0.40
621420	Outpatient Mental Health and Substance Abuse	0.02	0.07	0.13	0.13	0.35
621493	Freestanding Ambulatory and Emergency Centers	0.01	0.04	0.08	0.08	0.21
621610	Home Health Care Services	0.03	0.04	0.10	0.10	0.27
621910	Ambulance Services	0.03	0.04	0.10	0.10	0.28
622110	General Medical and Surgical Hospitals	2.2	7.0	13.9	13.9	36.9
622210	Psychiatric and Substance Abuse Hospitals	15.3	25.7	61.5	61.5	164
622310	Specialty (except Psychiatric, Substance Abuse) Hospitals	1.37	2.69	6.08	6.08	16.2
623110	Nursing Care Facilities (Skilled Nursing Facilities)	0.20	0.45	0.97	0.97	2.59

623210	Residential Intellectual and Developmental Disability	0.28	0.63	1.36	1.36	3.63
623220	Residential Mental Health and Substance Abuse	0.37	0.84	1.82	1.82	4.86
623311	Continuing Care Retirement Communities	0.13	0.36	0.73	0.73	1.96
623312	Assisted Living Facilities for the Elderly	0.05	0.14	0.28	0.28	0.74
623990	Other Residential Care Facilities	1.26	2.40	5.48	5.48	14.6
624110	Child and Youth Services	0.48	0.94	2.12	2.12	5.65
624120	Services for the Elderly and Persons with Disabilities	0.16	0.24	0.60	0.60	1.61
624190	Other Individual and Family Services	0.12	0.23	0.53	0.53	1.42
624210	Community Food Services	0.01	0.03	0.05	0.05	0.15
624221	Temporary Shelters*	-	-	-	-	-
624229	Other Community Housing Services	0.02	0.05	0.10	0.10	0.27
624230	Emergency and Other Relief Services	0.03	0.07	0.16	0.16	0.42
624310	Vocational Rehabilitation Services	0.14	0.31	0.68	0.68	1.81
	Firefighter-EMTs	0.13	0.25	0.57	0.57	1.52

Source: OSHA, 2023, based on BLS (2021) and BLS (2020b).
* By definition (see Section 1.4, above), there are no large Temporary Shelters.

Table C-8. WPV Incidents per Facility, Small Entities, all Ownerships

NAICS	NAICS Description	Recordable WPV Incidents		Non-Recordable WPV Incidents		Total Incidents per Facility
		Lost-Work	Non-Lost-Work	Other Physical	Other Threats	
621112	Offices of Physicians, Mental Health Specialists	0.00	0.00	0.00	0.00	0.00
621330	Offices of Mental Health Practitioners (excl. Physicians)	0.00	0.00	0.01	0.01	0.02
621420	Outpatient Mental Health and Substance Abuse	0.01	0.03	0.06	0.06	0.16
621493	Freestanding Ambulatory and Emergency Centers	0.01	0.02	0.04	0.04	0.12
621610	Home Health Care Services	0.01	0.01	0.03	0.03	0.09
621910	Ambulance Services	0.02	0.03	0.07	0.07	0.18
622110	General Medical and Surgical Hospitals	0.29	0.91	1.80	1.80	4.80
622210	Psychiatric and Substance Abuse Hospitals	2.91	4.90	11.7	11.71	31.2
622310	Specialty (except Psychiatric, Substance Abuse) Hospitals	0.20	0.39	0.88	0.88	2.35
623110	Nursing Care Facilities (Skilled Nursing Facilities)	0.12	0.29	0.62	0.62	1.64
623210	Residential Intellectual and Developmental Disability	0.09	0.19	0.42	0.42	1.12
623220	Residential Mental Health and Substance Abuse	0.12	0.27	0.59	0.59	1.56
623311	Continuing Care Retirement Communities	0.06	0.15	0.32	0.32	0.84
623312	Assisted Living Facilities for the Elderly	0.01	0.04	0.08	0.08	0.21
623990	Other Residential Care Facilities	0.19	0.37	0.84	0.84	2.23
624110	Child and Youth Services	0.05	0.09	0.21	0.21	0.57
624120	Services for the Elderly and Persons with Disabilities	0.03	0.05	0.12	0.12	0.33
624190	Other Individual and Family Services	0.01	0.02	0.04	0.04	0.11
624210	Community Food Services	0.01	0.01	0.03	0.03	0.08
624221	Temporary Shelters	0.02	0.04	0.10	0.10	0.26
624229	Other Community Housing Services	0.01	0.03	0.06	0.06	0.17

624230	Emergency and Other Relief Services	0.01	0.01	0.03	0.03	0.08
624310	Vocational Rehabilitation Services	0.05	0.11	0.24	0.24	0.65
	Firefighter-EMTs	0.01	0.03	0.06	0.06	0.16

Source: OSHA, 2023, based on BLS (2021) and BLS (2020b)

Note: All values are greater than zero but may appear as zero due to rounding

Table C-9. WPV Incidents per Facility, Very Small Entities, all Ownerships

NAICS	NAICS Description	Recordable WPV Incidents		Non-Recordable WPV Incidents		Total Incidents per Facility
		Lost-Work	Non-Lost-Work	Other Physical	Other Threats	
621112	Offices of Physicians, Mental Health Specialists	0.00	0.00	0.00	0.00	0.00
621330	Offices of Mental Health Practitioners (excl. Physicians)	0.00	0.00	0.00	0.00	0.01
621420	Outpatient Mental Health and Substance Abuse	0.00	0.01	0.02	0.02	0.04
621493	Freestanding Ambulatory and Emergency Centers	0.00	0.01	0.02	0.02	0.05
621610	Home Health Care Services	0.00	0.00	0.01	0.01	0.02
621910	Ambulance Services	0.00	0.01	0.02	0.02	0.05
622110	General Medical and Surgical Hospitals	0.00	0.02	0.03	0.03	0.08
622210	Psychiatric and Substance Abuse Hospitals	0.16	0.27	0.64	0.64	1.70
622310	Specialty (except Psychiatric, Substance Abuse) Hospitals	0.01	0.02	0.04	0.04	0.12
623110	Nursing Care Facilities (Skilled Nursing Facilities)	0.01	0.02	0.03	0.03	0.09
623210	Residential Intellectual and Developmental Disability	0.06	0.14	0.31	0.31	0.82
623220	Residential Mental Health and Substance Abuse	0.04	0.09	0.20	0.20	0.54
623311	Continuing Care Retirement Communities	0.01	0.02	0.03	0.03	0.09
623312	Assisted Living Facilities for the Elderly	0.00	0.01	0.03	0.03	0.07
623990	Other Residential Care Facilities	0.11	0.20	0.46	0.46	1.22
624110	Child and Youth Services	0.03	0.06	0.15	0.15	0.39
624120	Services for the Elderly and Persons with Disabilities	0.01	0.01	0.02	0.02	0.06
624190	Other Individual and Family Services	0.01	0.01	0.03	0.03	0.07
624210	Community Food Services	0.00	0.01	0.02	0.02	0.05
624221	Temporary Shelters	0.01	0.02	0.04	0.04	0.10
624229	Other Community Housing Services	0.01	0.01	0.03	0.03	0.08
624230	Emergency and Other Relief Services	0.00	0.01	0.01	0.01	0.04
624310	Vocational Rehabilitation Services	0.01	0.02	0.05	0.05	0.12
	Firefighter-EMTs	0.01	0.01	0.03	0.03	0.08

Source: OSHA, 2023, based on BLS (2021) and BLS (2020b).

Note: All values are greater than zero but may appear as zero due to rounding

C.5 Incidents Per-Facility, by Ownership

Table C-10 through Table C-13 present the estimated total number of WPV incidents per facility per year, by ownership category: for-profit, non-profit, state government, and local government establishments, respectively. These data are key inputs for the analyses of unit costs for the regulatory framework's various provisions.

Table C-10. Total WPV Incidents per Facility, For-Profit

NAICS	NAICS Description	Total WPV Incidents per Facility		
		Large	Small	Very Small
621112	Offices of Physicians, Mental Health Specialists	-	0.0	0.0
621330	Offices of Mental Health Practitioners (except Physicians)	-	0.02	0.01
621420	Outpatient Mental Health and Substance Abuse Centers	0.18	0.10	0.03
621493	Freestanding Ambulatory Surgical and Emergency Centers	0.20	0.11	0.05
621610	Home Health Care Services	0.25	0.08	0.02
621910	Ambulance Services	0.31	0.20	0.04
622110	General Medical and Surgical Hospitals	16.46	2.51	0.06
622210	Psychiatric and Substance Abuse Hospitals	62.9	29.6	0.8
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	3.71	1.56	0.04
623110	Nursing Care Facilities (Skilled Nursing Facilities)	2.12	1.56	0.08
623210	Residential Intellectual and Developmental Disability Facilities	1.01	0.91	0.36
623220	Residential Mental Health and Substance Abuse Facilities	3.25	1.64	0.37
623311	Continuing Care Retirement Communities	1.02	0.48	0.08
623312	Assisted Living Facilities for the Elderly	0.69	0.20	0.07
623990	Other Residential Care Facilities	2.42	1.29	0.52
624110	Child and Youth Services	0.92	0.38	0.15
624120	Services for the Elderly and Persons with Disabilities	1.31	0.33	0.05
624190	Other Individual and Family Services	0.16	0.05	0.02
624210	Community Food Services	0.15	0.08	0.04
624221	Temporary Shelters	-	0.15	0.05
624229	Other Community Housing Services	-	0.07	0.04
624230	Emergency and Other Relief Services	0.08	0.02	0.02
624310	Vocational Rehabilitation Services	0.57	0.29	0.08
	Firefighter-EMTs	1.85	-	-

Source: OSHA, 2023.

Table C-11. Total WPV Incidents per Facility, Non-Profit

NAICS	NAICS Description	Total WPV Incidents per Facility		
		Large	Small	Very Small
621112	Offices of Physicians, Mental Health Specialists	-	0.0	0.0
621330	Offices of Mental Health Practitioners (except Physicians)	-	0.05	0.03
621420	Outpatient Mental Health and Substance Abuse Centers	0.38	0.21	0.05
621493	Freestanding Ambulatory Surgical and Emergency Centers	0.30	0.17	0.05
621610	Home Health Care Services	0.47	0.16	0.02
621910	Ambulance Services	0.20	0.13	0.06
622110	General Medical and Surgical Hospitals	32.39	4.94	0.06
622210	Psychiatric and Substance Abuse Hospitals	76.1	35.8	-
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	10.59	4.45	0.06
623110	Nursing Care Facilities (Skilled Nursing Facilities)	2.73	2.01	0.13
623210	Residential Intellectual and Developmental Disability Facilities	1.41	1.27	0.45
623220	Residential Mental Health and Substance Abuse Facilities	2.99	1.51	0.47
623311	Continuing Care Retirement Communities	3.44	1.61	0.11
623312	Assisted Living Facilities for the Elderly	0.84	0.25	0.09
623990	Other Residential Care Facilities	5.14	2.74	0.76
624110	Child and Youth Services	1.46	0.60	0.20
624120	Services for the Elderly and Persons with Disabilities	1.30	0.33	0.07
624190	Other Individual and Family Services	0.44	0.14	0.05
624210	Community Food Services	0.15	0.08	0.05
624221	Temporary Shelters	-	0.26	0.10
624229	Other Community Housing Services	-	0.17	0.08
624230	Emergency and Other Relief Services	0.44	0.08	0.04
624310	Vocational Rehabilitation Services	1.54	0.77	0.11
	Firefighter-EMTs	-	-	-

Source: OSHA, 2023.

Table C-12. Total WPV Incidents per Facility, State-Government

NAICS	NAICS Description	Total WPV Incidents per Facility		
		Large	Small	Very Small
621112	Offices of Physicians, Mental Health Specialists	0.3	NA	0.2
621330	Offices of Mental Health Practitioners (except Physicians)	-	NA	-
621420	Outpatient Mental Health and Substance Abuse Centers	3.40	NA	0.69
621493	Freestanding Ambulatory Surgical and Emergency Centers	1.44	NA	0.49
621610	Home Health Care Services	1.37	NA	0.16
621910	Ambulance Services	-	NA	-
622110	General Medical and Surgical Hospitals	558.99	NA	1.40
622210	Psychiatric and Substance Abuse Hospitals	194.2	NA	2.3
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	84.35	NA	0.70
623110	Nursing Care Facilities (Skilled Nursing Facilities)	35.01	NA	1.57
623210	Residential Intellectual and Developmental Disability Facilities	67.69	NA	23.59
623220	Residential Mental Health and Substance Abuse Facilities	43.79	NA	9.66
623311	Continuing Care Retirement Communities	19.15	NA	1.45
623312	Assisted Living Facilities for the Elderly	1.32	NA	0.30
623990	Other Residential Care Facilities	66.40	NA	17.05
624110	Child and Youth Services	29.96	NA	8.50
624120	Services for the Elderly and Persons with Disabilities	20.88	NA	2.60
624190	Other Individual and Family Services	9.23	NA	2.53
624210	Community Food Services	-	NA	-
624221	Temporary Shelters	-	NA	-
624229	Other Community Housing Services	-	NA	-
624230	Emergency and Other Relief Services	-	NA	-
624310	Vocational Rehabilitation Services	4.21	NA	0.51
	Firefighter-EMTs	3.04	NA	0.80

Source: OSHA, 2023.

Table C-13. Total WPV Incidents per Facility, Local-Government

NAICS	NAICS Description	Total WPV Incidents per Facility		
		Large	Small	Very Small
621112	Offices of Physicians, Mental Health Specialists	0.0	0.0	-
621330	Offices of Mental Health Practitioners (except Physicians)	0.40	0.03	0.02
621420	Outpatient Mental Health and Substance Abuse Centers	1.48	0.24	0.06
621493	Freestanding Ambulatory Surgical and Emergency Centers	1.48	0.18	0.08
621610	Home Health Care Services	0.30	0.14	0.03
621910	Ambulance Services	0.30	0.19	0.07
622110	General Medical and Surgical Hospitals	27.06	6.31	0.08
622210	Psychiatric and Substance Abuse Hospitals	68.2	32.1	-
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	4.20	-	-
623110	Nursing Care Facilities (Skilled Nursing Facilities)	12.83	3.31	0.17
623210	Residential Intellectual and Developmental Disability Facilities	4.51	1.65	0.60
623220	Residential Mental Health and Substance Abuse Facilities	3.52	2.30	0.64
623311	Continuing Care Retirement Communities	1.30	0.61	0.13
623312	Assisted Living Facilities for the Elderly	0.39	0.12	0.11
623990	Other Residential Care Facilities	8.68	3.19	0.95
624110	Child and Youth Services	5.72	0.84	0.28
624120	Services for the Elderly and Persons with Disabilities	0.83	0.51	0.09
624190	Other Individual and Family Services	1.55	0.17	0.06
624210	Community Food Services	0.14	0.08	0.07
624221	Temporary Shelters	-	0.26	0.16
624229	Other Community Housing Services	0.27	0.26	0.12
624230	Emergency and Other Relief Services	0.17	0.12	0.06
624310	Vocational Rehabilitation Services	1.23	0.62	0.15
	Firefighter-EMTs	1.22	0.17	0.07

Source: OSHA, 2023.

Appendix C Addendum: Descriptions of Data and Calculations for WPV Incident Analysis [42]

This document presents the data sources and step-by-step calculation for one 6-digit NAICS industry (622210 - Psychiatric and Substance Abuse Hospitals) for the WPV Incident Analysis leading up to Table C-6 (WPV Incidents per Year, by Healthcare Setting and Facility Size). Some of the calculated values presented may not sum due to rounding.

Data Sources

The following source data for NAICS code 622210 were used in the calculations:

BLS 2018 Survey of Occupational Injuries and Illnesses (SOII)

NAICS Code	Description (NAICS codes for industries)	Ownership	Event or Exposure	Incidence Rate
622210	Psychiatric and Substance Abuse Hospitals	Private	111 Intentional injury by other person	124.9
622210	Psychiatric and Substance Abuse Hospitals	Private	1214 Injured by physical contact with person while restraining-subduing--unintentional	42.8
622000	Hospitals	Private	111 Intentional injury by other person	9.7
622000	Hospitals	State Government	111 Intentional injury by other person	105.4
622000	Hospitals	Local Government	111 Intentional injury by other person	15.1
622000	Hospitals	Private	1214 Injured by physical contact with person while restraining-subduing--unintentional	2.4
622000	Hospitals	State Government	1214 Injured by physical contact with person while restraining-subduing--unintentional	55.2
622000	Hospitals	Local Government	1214 Injured by physical contact with person while restraining-subduing--unintentional	2.8

[42] Because BLS SOII does not report WPV incidence rates at the five- and six-digit NAICS industry level for all ownership groups and all size categories, OSHA in this addendum, estimated WPV incidence rates using the data reported by BLS SOII at the three-digit NAICS industry level, by ownership group. The reported BLS data are shown in the tables on this page and the following page. Combined with Census's County Business Patterns data for employment by enterprise size and employment type (shown in the tables on the following page), the reported BLS SOII data enabled OSHA to estimate WPV incidence rates and the number of WPV incidents by ownership group and size category. OSHA requests public comment on the analytical methodology presented in this addendum.

BLS Current Employment Statistics Survey – Employment, Hours, and Earnings

NAICS Code	Description (NAICS codes for industries)	BLS NAICS	Hours Worked	Ratio to FTE
622210	Psychiatric and Substance Abuse Hospitals	621112	34.8	87%

Note: Data Extracted March 5, 2020.

2017 County Business Patterns Data for NAICS Code 622210 (Psychiatric and Substance Abuse Hospitals)

Employment Type	Total
Total Employment	228,816
Non-profit Employees	40,303
Government Hospitals Employees	94,198

2017 County Business Patterns and 2017 Economic Census for NAICS Code 622210 (Psychiatric and Substance Abuse Hospitals)

Enterprise Employment Size	Employment
01: Total	228,816
02: <5	6
04: 10-19	58
05: <20	69
06: 20-99	1,582
07: 100-499	45,392
08: <500	47,043
09: 500+	181,773

BLS, 2019 Incidence rates of nonfatal occupational injuries and illnesses by industry and case types (6222 - Psychiatric and substance abuse hospitals)

Total recordable cases	Cases with days away from work, job restriction, or transfer			Other recordable cases
	Total	Cases with days away from work	Cases with days of job transfer or restriction	
7.2	4.1	2.5	1.6	3.2

Note: The incidence rates represent the number of injuries and illnesses per 100 full-time workers.

Step-by-Step Calculations

Step 1. Obtain lost-work day incidence rate in private (for-profit) sector

- From BLS 2018 SOII data, Psychiatric and Substance Abuse Hospitals reported a rate of 124.9 intentional injury by other person incidents per 10,000 FTE and 42.8 unintentional injured by physical contact with person while restraining/subduing incidents per 10,000 FTE for a total incidence rate of 167.7 recorded per 10,000 FTE.

- Values are presented in Table C-1.
- Please note that private incidence rates are provided for the 4-digit NAICS level, and we assume the same rates apply to the 6-digit NAICS industries.

Step 2. Calculate incidence rates for state government entities

- To estimate the state government incidence rates, apply the ratio of the state government general hospital rate divided by the private general hospital rate.
    - The rate of intentional injury by other person incidents for a state government general hospital is 105.4 per 10,000 FTE and the private rate is 9.7 per 10,000 FTE, yielding a ratio of 10.8 (105.4 ÷ 9.7).
    - The rate of unintentional injury by physical contact with person while restraining/subduing incidents for a state government general hospital is 55.2 per 10,000 FTE and the private rate is 2.4 per 10,000 FTE, yielding a ratio of 22.9 (55.2 ÷ 2.4).
- To estimate the state government incidence rates for Psychiatric and Substance Abuse Hospitals, multiply the private rates for each event type and then sum the two results.
    - The rate of intentional injury in a state Psychiatric and Substance Abuse Hospital is estimated to be 1,357.2 per 10,000 FTE (124.9 x 10.8).
    - The rate of unintentional injury by physical contact with person while restraining/subduing incidents in a state Psychiatric and Substance Abuse Hospital is estimated to be 984.4 per 10,000 FTE (42.8 x 22.9).
    - Summed, the total incidence rate for state government Psychiatric and Substance Abuse Hospitals with days away from work is estimated to be 2,341.6 (1,357.2 + 984.4).
- Values are presented in Table C-2.

Step 3. Calculate incidence rates for Local Government entities

- Step 3 repeats Step 2 apart from using the ratio of the local government general hospital rate divided by the private general hospital rate.
    - The rate of intentional injury by other person incidents for a local government general hospital is 15.1 per 10,000 FTE and the private rate is 9.7 per 10,000 FTE, yielding a ratio of 1.6 (15.1 ÷ 9.7).
    - The rate of unintentional injury by physical contact with person while restraining/subduing incidents for a local government general hospital is 2.8 per 10,000 FTE and the private rate is 2.4 per 10,000 FTE, yielding a ratio of 1.2 (2.8 ÷ 2.4).
- To estimate the local government incidence rates for Psychiatric and Substance Abuse Hospitals, multiply the private rates for each event type and then sum the two results.
    - The rate of intentional injury in a local Psychiatric and Substance Abuse Hospital is estimated to be 194.4 per 10,000 FTE (124.9 x 1.6).
    - The rate of unintentional injury by physical contact with person while restraining/subduing incidents in a local government Psychiatric and Substance Abuse Hospital is estimated to be 49.9 per 10,000 FTE (42.8 x 1.2).

    - Summed, the total incidence rate for local government Psychiatric and Substance Abuse Hospitals with days away from work is estimated to be 244.4 (194.4 + 49.9).
- Values are presented in Table C-3.

Step 4. Obtain average weekly hours worked (BLS' Current Employment Statistics survey)

- As not all employees are FTEs and the rates estimated in Steps 1, 2, and 3 are per FTE, all employees must be accounted for.
    - Obtain data describing the average hours worked per week for employees from BLS' Current Employment Statistics survey by NAICS code for 2015 to 2018.
    - The average weekly hours worked in Psychiatric and Substance Abuse Hospitals was 34.8 hours, or 87 percent of the hours for an FTE.
- Values are presented in Table C-4.

Step 5. Estimate the number of employees for large entities

- Estimate total private employment:
    - According to US Census Bureau 2017 County Business Pattern data, Psychiatric and Substance Abuse Hospitals employed a total of 228,816 people.
    - Subtract the non-profit employees legal form of organization (LFO): N): 40,303 people.
    - Subtract 94,198 employed by Government Hospitals (LFO: G).
    - Total private (for-profit) Psychiatric and Substance Abuse Hospital employment is estimated to be 94,315 (228,816 - 40,303 – 94,198).
- Estimate SBA-defined small private employment:
    - According to US Census Bureau 2017 County Business Pattern and 2017 Economic Census data, SBA-defined small Psychiatric and Substance Abuse Hospitals employed a total of 47,038 people
    - Subtract the estimated SBA-defined small non-profit employees: 8,285 people.
        - The SBA-defined small non-profit employees are estimated as scaled to reflect the SBA-defined small portion of the total employment for Psychiatric and Substance Abuse Hospitals. In other words, the total SBA-defined small employment is multiplied by the total non-profit employees, divided by the total employees.
        - The equation: 8,285 people = 47,038 x (40,303 ÷ 228,816)
    - Subtract the estimated 19,364 employed by SBA-defined small Government Hospitals.
        - The SBA-defined small government employees are estimated as scaled to reflect the SBA-defined portion of the total employment for Psychiatric and Substance Abuse Hospitals. In other words, the total SBA-defined small employment is multiplied by the total government employees, divided by the total employees.
        - The equation: 19,364 people = 47,038 x (94,198 ÷ 228,816)
    - Total private Psychiatric and Substance Abuse Hospital employment is estimated to be 19,388 (47,038 - 8,285– 19,364).

- Total private employment for large entities is the SBA-defined small private employment subtracted from the total private employment, or 74,927 (94,315 – 19,388).

Step 6. Estimate number of recordable lost-workday WPV incidents, large-private facilities

- To estimate the number of reported/investigated incidents:
    - First, take the total rate calculated in Step 1 and presented in Table C-1 (167.7 recorded per 10,000 FTE).
    - Next scale to total employees in large-private facilities
        - Multiply it by the total employees (74,927),
        - Multiply by the average weekly hours worked (Step 4 and Table C-4), and
        - Divide by 10,000 for consistent units.
    - Equation: 167.7 x (74,927 x 87% ÷ 10,000) = 1,093.2 reported/investigated incidents.
- To correct for the under-reporting of WPV incidents in the healthcare sector error, multiply the number of reported/investigated incidents by (1 ÷ 0.85) (described in Section C.2).
    - 1,093.2 x (1 ÷ 0.85) = 1,286.1 total recordable, WPV, lost-work incidents

Step 7. Estimate total recordable WPV incidents and recordable WPV non-lost-work incidents, large-private, for-profit facilities

- As described in Section C.3, the total recordable WPV incidents comprises those resulting in lost-work days and those not resulting in lost-work days (or non-lost-workday incidents).
- The ratio of total recordable incidents to total lost-work incidents for psychiatric and substance abuse hospitals, 2.68, presented in Table C-5, is derives from 2019 BLS data.[43]
    - In 2019, psychiatric and substance abuse hospitals had a total of 7.2 recordable cases per 100 FTE, of which 2.5 cases per 100 FTE resulted in days away from work.
    - OSHA scaled both rates up by 0.3 to correct for the under-reporting of WPV incidents [0.3 = 1.68 (intentional/restrained rate 168 per 10,000 FTE) X ((1-0.85)/0.85)]
        - 7.2 + 0.3 = 7.5
        - 2.5 + 0.3 = 2.8
    - The ratio, 2.68 = 7.5 ÷ 2.8
- Total recordable WPV incidents for psychiatric and substance abuse hospitals is estimated to be 3,448 (1,286.1 total recordable, WPV, lost-work incidents x 2.68 total recordable incidents/total lost-work incidents).
- Thus recordable, WPV, non-lost-work incidents is 2,162 (3,448 total recordable – 1,286 recordable, WPV, lost-work incidents).

Step 8. Estimate other physical incidents, large-private, for-profit facilities

[43] TABLE 1. Incidence rates of nonfatal occupational injuries and illnesses by industry and case types, 2019 (bls.gov)

- As described in Section C.3, OSHA, based on professional judgment, estimated that the number of incidents of other physical injuries to be 150 percent of total recordable WPV incidents.
- As calculated in Step 7, large, private psychiatric and substance abuse hospitals were estimated to have experienced 3,448 total recordable WPV incidents.
- Multiplying 150% by of total recordable WPV incidents yields 5,172 other physical incidents (150% x 3,448).

Step 9. Estimate other threat incidents, large-private, for-profit facilities

- As described in Section C.3, OSHA, based on professional judgment, estimated that the number of incidents of other threat injuries to be 150 percent of total recordable WPV incidents.
- As calculated in Step 7, large, private psychiatric and substance abuse hospitals were estimated to have experienced 3,448 total recordable WPV incidents.
- Multiplying 150% by of total recordable WPV incidents yields 5,172 other threat incidents (150% x 3,448).

Step 10. Sum and Categorize for large-private, for-profit facilities

- Steps 6 through 10 yield inputs to Table C-6 for the Behavioral Health category as 622210 - Psychiatric and Substance Abuse Hospitals falls in that category.

Setting and Size	**WPV Recordable, Lost-Work Incidents**	**WPV Recordable, Non-Lost-Work Incidents**	**Total Recordable WPV Incidents**	**Other Physical Incidents**	**Other Threat Incidents**	**Total WPV Incidents (recordable and non-recordable)**
Column:	**A**	**B**	**C = A + B**	**D = C x 150%**	**E = C x 150%**	**F = C + D + E**
Step:	**Steps 1-6**	**Step 7**	**Step 7**	**Step 8**	**Step 9**	**Step 10**
Psychiatric and Substance Abuse Hospitals	1,286	2,162	3,448	5,172	5,172	13,792

Step 11. Repeat steps 6 through 10 for SBA-defined small and very small private, for-profit facilities
Step 12. Repeat steps 6 through 11 for private, non-profit and public (state and local) facilities

Appendix D: Engineering Control Equipment Unit Costs

Table D-1 gives the unit cost prices for various control equipment used in the cost analysis. Unit prices are based on prices for a sample of comparable equipment found in the market. Further details on the sources for these unit costs are shown in Table D-2. These costs do not include the 20 percent mark-up OSHA applies for installation in the cost analysis (see Section 2.4.1).

Table D-1. Engineering and Work Practice Control Equipment Unit Costs

Control Name	Small Size/Cost	Large Size/Cost	Units	Notes	Source (See Table D-2 for further details)
Indoor lights	$250	$250	Per new indoor light fixture	Metalux RCG 4-ft 18.6W LED Linear Recessed Troffer	warehouse-lighting.com and LBClighting.com
Outdoor lights	$700	$700	Per new outdoor light fixture	ED Parking Lot Light Fixture, 4000K Color Temperature, 120 to 277VAC, Pole Mount Type	Grainger Industrial Supply
Circular or curved mirrors	$50	$50	Per mirror	Convex Mirror - 26" Glass, Indoor	Uline
Electronic access controls	$1,000	$2,000	Per system	Incl. control unit, power, 10 credentials, 1 reader	Dormakaba
Enclosed workstations with shatter-resistant glass	$250	$250	Per workstation	PLEXIGLASS Sheet - Acrylic Sheet - EXTRUDED (0.25" thick, 48" x 96")	Professional Plastics
Deep service counters	$8,000	$8,000	Per counter	Assume 6', 42" h: Frame = $2,380; Filler = $1,420; Exterior ladding=$2,022; Interior cladding $815; toe kick $750; back panel $485	Herman Miller
Opaque glass in patient rooms	$25	$25	Per room	Gila 4 ft. x 6.5 ft. Frosted Privacy Window Film	Home Depot
Separate rooms or areas for high-risk patients	$500	$500	Per room	Town Steel ADA-5 Point Anti-Ligature Arched Lock Series	Craft master hardware

Table D-2, continued. Engineering and Work Practice Control Equipment Unit Costs

Control Name	Small Size/Cost	Large Size/Cost	Units	Notes	Source (See Table D-2 for further details)
Two-way radios	$50	$50	Per radio	Midland - GXT1030VP4	Amazon
Paging system	$900	$3,900	Per system	Small: ALPHA TXT PAGER (6); Large: ALPHA TXT PAGER (48)	Pagertech.com
Paging System	$950	$2,240	Per system	SlimLine2 Pager System	Microframecorp.com
Personal panic devices	$50	$50	Per panic device	Supervised Long Range Transmitter DXS-LRC SST00124	BEC Integrated Solutions
Weapon detector, handheld	$150	$150	Per handheld detector	SuperWand	Garrett
CCTV System	$1,000	$8,000	Per system	Cantek PT8MPTZ2TB Powerful 8 Channel Pan/Tilt/Zoom 1080P HD Security System	Surveillance-Video
Locks on doors	$225	$225	Per lock	CL2255 Electronic Tubular Mortise Latch	CodeLocks America

Source: OSHA, 2023.

Table D-3. Engineering and Work Practice Control Equipment, Product and Source Data

Control Name	Vendor	Product name	Price per unit	URL
Two-way radios	Amazon.com	Midland - GXT1030VP4	$35	https://www.amazon.com
Two-way radios	Amazon.com	Arcshell Rechargeable Long Range Two-Way Radios with Earpiece	$13	https://www.amazon.com
Two-way radios	Amazon.com	DEWALT DXFRS800	$65	https://www.amazon.com
Paging System	Microframecorp.com	SlimLine2 10 Pager System	$949	https://microframecorp.com
Paging System	Microframecorp.com	SlimLine2 40 Pager System	$2,243	https://microframecorp.com
Paging System	Pagertec.com	ALPHA TXT PAGER (6)	$923	https://www.pagertec.com
Paging System	Pagertec.com	ALPHA TXT PAGER (12)	$1,313	https://www.pagertec.com
Paging System	Pagertec.com	ALPHA TXT PAGER (48)	$3,950	https://www.pagertec.com
Paging System	Pagertec.com	TrackStaff Paging (10)	$765	https://www.pagertec.com
Paging System	Pagertec.com	TrackStaff Paging (20)	$1,189	https://www.pagertec.com
Separate rooms or areas for high-risk patients (anti-ligature hardware)	craftmasterhardware.com	Glynn-Johnson HL6 Push/Pull Latch (Hospital Latch)	$169	https://www.craftmasterhardware.com
Separate rooms or areas for high-risk patients (anti-ligature hardware)	craftmasterhardware.com	Corbin Russwin Behavioral Health Lock Series with BHSS Trim	$831	https://www.craftmasterhardware.com
Separate rooms or areas for high-risk patients (anti-ligature hardware)	craftmasterhardware.com	Town Steel ADA-5 Point Anti-Ligature Arched Lock Series	$476	https://www.craftmasterhardware.com
Separate rooms or areas for high-risk patients (anti-ligature hardware)	craftmasterhardware.com	Town Steel ADA-Anti-Ligature Mortise Locks	$469	https://www.craftmasterhardware.com
Weapon detector, handheld	Garrett	Super Scanner V	-	https://www.garrett.com

Table D-4, continued. Engineering and Work Practice Control Equipment, Product and Source

Control Name	Vendor	Product name	Price per unit	URL
Weapon detector, handheld	Amazon.com	SuperWand	$138	https://www.amazon.com
Weapon detector, handheld	Garrett	SuperWand	-	https://www.garrett.com
Weapon detector, handheld	Amazon.com	Hunter Professional Hand Held Metal Detector Security Wand with Adjustable Sensitivity, Sound & Vibration Modes.	$99	https://www.amazon.com
Indoor lights	warehouse-lighting.com	WareLight Industrial Lighting Fixtures 4 Foot LED Direct/Indirect Grille Fixture with Steel Perforated Diffuser	$203	https://www.warehouse-lighting.
Indoor lights	warehouse-lighting.com	WareLight Industrial Lighting Fixtures 4 FOOT LED SUSPENDED LINEAR FIXTURE	$258	https://www.warehouse-lighting.com
Indoor lights	LBClighting.com	Metalux RCG 4-ft 18.6W LED Linear Recessed Troffer	$252	https://www.lbclighting.com
Outdoor lights	Grainger	LED Parking Lot Light Fixture, 4000K Color Temperature, 120 to 277VAC, Pole Mount Type, 7573 lm	$763	https://www.grainger.com
Outdoor lights	Grainger	LED Parking Lot Light Fixture, 4000K Color Temperature, 120 to 277VAC, Pole Mount Type	$633	https://www.grainger.com
Outdoor lights	Grainger	LED Parking Lot Light Fixture, 5000K Color Temperature, 120 to 277VAC, Pole Mount Type	$1,924	https://www.grainger.com
Circular or curved mirrors	Uline.com	Convex Mirror - 12" Glass, Indoor	$30	https://www.uline.com
Circular or curved mirrors	Uline.com	Convex Mirror - 26" Glass, Indoor	$69	https://www.uline.com
Circular or curved mirrors	Uline.com	Half-Dome Safety Mirror - 18"	$38	https://www.uline.com
Circular or curved mirrors	Uline.com	Half-Dome Safety Mirror - 26"	$71	https://www.uline.com
Deep service counters	Herman Miller	Commend™ Nurses Station	$8,000	https://www.hermanmiller.com
Locks on doors	Bestaccess.com	40H SERIES	$246 - $831	https://www.bestaccess.com
Locks on doors	Bestaccess.com	SPSL, SSRL, SPSE	$1,118 - $1,526	https://www.bestaccess.com
Locks on doors	CodeLocks Americas	CL600 Panic Access Kit	$369	https://www.codelocks.us
Locks on doors	CodeLocks Americas	CL2255 Electronic Tubular Mortise Latch	$225	https://www.codelocks.us
Electronic access controls	Dormakaba	Keyscan LUNA SDAC Smart Kit	$1,171	https://www.dormakaba.com
Electronic access controls	Dormakaba	Keyscan control unit, 1 to 8 readers	$1,300 - $5,277	https://www.dormakaba.com

Table D-4, continued. Engineering and Work Practice Control Equipment, Product and Source

Control Name	Vendor	Product name	Price per unit	URL
Electronic access controls	Dormakaba	Keyscan Aurora (control management software)	$1,557	https://www.dormakaba.com
Electronic access controls	Dormakaba	Keyscan K-SMART3 Reader Program Card (5)	$33	https://www.dormakaba.com
Electronic access controls	Dormakaba	Keyscan Proximity Reader	$228	https://www.dormakaba.com
Electronic access controls	Dormakaba	Keyscan Proximity Keypad Reader	$765	https://www.dormakaba.com
Enclosed workstations with shatter-resistant glass	Professional Plastics	PLEXIGLASS Sheet - Acrylic Sheet - EXTRUDED (0.1" thick, 12" x 12")	$55	https://www.professionalplastics.com
Enclosed workstations with shatter-resistant glass	Professional Plastics	PLEXIGLASS Sheet - Acrylic Sheet - EXTRUDED (0.25" thick, 48" x 96")	$236	https://www.professionalplastics.com
Opaque glass in patient rooms	Smart Tint	Smart Tint® film 4 ft. x 6.5 ft.	$1,534	https://www.smarttint.com
Opaque glass in patient rooms	Home Depot	Gila 4 ft. x 6.5 ft. Frosted Privacy Window Film	$24	https://www.homedepot.com
Personal panic devices	BEC Integrated Solutions	Wireless Panic Button Pre-programmed Commercial Security System	$1,979	https://becintegrated.com
Personal panic devices	BEC Integrated Solutions	Supervised Long Range Transmitter DXS-LRC SST00124	$33	https://becintegrated.com
CCTV system	Surveillance-Video	RVS Systems RVS-AR-DVR Mobilemule 4 Channel DVR with GPS Tracking and AHD Dome Camera, Western Digital 1TB 2.5 Inch Hard Drive, 66' Camera Cable	$554	https://www.surveillance-video.com
CCTV system	Surveillance-Video	Vivotek ND8322P-2FE80 8 Channel NVR with No HDD with 2 X 5MP Indoor Fisheye IP Security Cameras	$924	https://www.surveillance-video.com
CCTV system	Surveillance-Video	Cantek PT8MPTZ2TB Powerful 8 Channel Pan/Tilt/Zoom 1080P HD Security System	$1,972	https://www.surveillance-video.com
CCTV system	Surveillance-Video	Cantek PT16MPTZ4TB Powerful 16 Channel Pan/Tilt/Zoom 1080P HD Security System	$3,897	https://www.surveillance-video.com
CCTV system	Surveillance-Video	Cantek PT32MPTZ6TB Powerful 32 Channel Pan/Tilt/Zoom 1080P HD Security System	$8,222	https://www.surveillance-video.com

Source: OSHA, 2022.

Appendix E: Average Per-Facility Engineering Control Costs, by Control Type and NAICS (All Ownerships)

Table E-1, Table E-2, and Table E-3 present per-facility control equipment costs, by control type, on a weighted-average basis across all ownership categories for large, small, and very small facilities, respectively.

Table E-1. Engineering Control Equipment Cost per Facility, Large Facilities, all Ownerships ($2019)

NAICS	Two-way radios	Panic devices	Paging system	Access controls	Enclosed workstations	Deep service counters	Locks	CCTV System	Indoor lights	Outdoor lights	Separate rooms	Opaque glass	Mirrors	Weapon detector
621112	$92	$92	$373	$459	$94	$3,006	$1,057	$1,503	$1,174	$1,972	$781	$78	$78	$28
621330	$220	$220	$893	$1,099	$111	$3,539	$1,244	$1,770	$1,383	$2,323	$920	$92	$92	$33
621420	$154	$154	$624	$768	$55	$1,763	$620	$881	$689	$1,157	$458	$46	$46	$17
621493	$112	$112	$457	$562	$5	$152	$53	$379	$296	$498	$39	$4	$4	$6
621610	$438	$438	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
621910	$214	$214	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
622110	$5,211	$5,211	$21,168	$26,053	$141	$4,520	$1,589	$11,300	$8,828	$14,831	$1,174	$117	$117	$176
622210	$668	$668	$2,716	$3,342	$600	$19,200	$6,750	$9,600	$7,500	$12,600	$4,988	$499	$499	$180
622310	$1,139	$1,139	$4,627	$5,695	$36	$1,140	$401	$2,849	$2,226	$3,740	$296	$30	$30	$44
623110	$586	$586	$2,381	$2,931	$51	$1,618	$569	$4,046	$3,161	$5,310	$420	$42	$42	$52
623210	$107	$107	$435	$535	$55	$1,745	$613	$873	$682	$1,145	$453	$45	$45	$16
623220	$203	$203	$826	$1,016	$81	$2,591	$911	$1,296	$1,012	$1,701	$673	$67	$67	$24
623311	$645	$645	$2,621	$3,225	$51	$1,621	$570	$4,052	$3,166	$5,318	$421	$42	$42	$53
623312	$236	$236	$960	$1,182	$21	$668	$235	$1,671	$1,305	$2,193	$174	$17	$17	$22
623990	$159	$159	$645	$794	$12	$369	$130	$923	$721	$1,211	$96	$10	$10	$12
624110	$194	$194	$789	$971	$13	$423	$149	$1,056	$825	$1,386	$110	$11	$11	$7
624120	$541	$541	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
624190	$226	$226	$917	$1,129	$15	$482	$169	$1,205	$941	$1,581	$125	$13	$13	$8
624210	$44	$44	$180	$221	$3	$101	$35	$252	$197	$330	$26	$3	$3	$2
624221	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
624229	$40	$40	$163	$201	$1	$39	$14	$98	$77	$129	$10	$1	$1	$1
624230	$132	$132	$536	$660	$9	$299	$105	$748	$584	$982	$78	$8	$8	$5
624310	$168	$168	$682	$839	$12	$389	$137	$972	$759	$1,275	$101	$10	$10	$6
Fire EMT	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Source: OSHA, 2022.
Note: NA = no establishments; A $0 indicates zero cost for these establishments.

Table E-2. Engineering Control Equipment Cost per Facility, Small Facilities, all Ownerships ($2019)

NAICS	Two-way radios	Panic devices	Paging system	Access controls	Enclosed workstations	Deep service counters	Locks	CCTV System	Indoor lights	Outdoor lights	Separate rooms	Opaque glass	Mirrors	Weapon detector
621112	$20	$20	$153	$102	$20	$633	$223	$40	$247	$416	$63	$6	$6	$6
621330	$26	$26	$195	$130	$20	$646	$227	$40	$252	$424	$80	$8	$8	$6
621420	$83	$83	$620	$413	$27	$872	$307	$54	$341	$572	$227	$23	$23	$8
621493	$62	$62	$466	$311	$3	$87	$30	$27	$169	$284	$23	$2	$2	$3
621610	$147	$147	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
621910	$136	$136	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
622110	$815	$815	$6,110	$4,073	$22	$713	$251	$223	$1,393	$2,340	$185	$19	$19	$28
622210	$792	$792	$5,944	$3,962	$282	$9,037	$3,177	$565	$3,530	$5,931	$2,348	$235	$235	$85
622310	$474	$474	$3,552	$2,368	$16	$527	$185	$165	$1,029	$1,728	$137	$14	$14	$21
623110	$427	$427	$3,199	$2,133	$37	$1,181	$415	$369	$2,306	$3,874	$307	$31	$31	$38
623210	$87	$87	$649	$433	$29	$920	$323	$57	$359	$604	$239	$24	$24	$9
623220	$103	$103	$770	$513	$29	$916	$322	$57	$358	$601	$287	$29	$29	$9
623311	$303	$303	$2,274	$1,516	$24	$756	$266	$236	$1,477	$2,481	$196	$20	$20	$25
623312	$73	$73	$551	$367	$6	$206	$72	$64	$403	$676	$54	$5	$5	$7
623990	$83	$83	$622	$415	$6	$197	$69	$62	$385	$646	$51	$5	$5	$6
624110	$69	$69	$516	$344	$5	$159	$56	$50	$311	$523	$41	$4	$4	$3
624120	$139	$139	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
624190	$58	$58	$436	$290	$4	$136	$48	$42	$266	$446	$35	$4	$4	$2
624210	$25	$25	$186	$124	$2	$56	$20	$18	$110	$184	$15	$1	$1	$1
624221	$59	$59	$440	$293	$2	$56	$20	$18	$110	$184	$34	$3	$3	$1
624229	$38	$38	$285	$190	$2	$57	$20	$18	$111	$186	$22	$2	$2	$1
624230	$25	$25	$190	$127	$2	$57	$20	$18	$112	$188	$15	$1	$1	$1
624310	$97	$97	$727	$484	$7	$225	$79	$70	$439	$737	$58	$6	$6	$4
Fire EMT	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Source: OSHA, 2022.
Note: A $0 indicates zero cost for these establishments.

Table E-3. Engineering Control Equipment Cost per Facility, Very Small Facilities, all Ownerships ($2019)

NAICS	Two-way radios	Panic devices	Paging system	Access controls	Enclosed workstations	Deep service counters	Locks	CCTV System	Indoor lights	Outdoor lights	Separate rooms	Opaque glass	Mirrors	Weapon detector
621112	$14	$14	$104	$70	$6	$197	$69	$12	$77	$130	$32	$3	$3	$2
621330	$13	$13	$99	$66	$6	$200	$70	$12	$78	$131	$31	$3	$3	$2
621420	$23	$23	$175	$116	$7	$213	$75	$13	$83	$140	$55	$6	$6	$2
621493	$29	$29	$214	$143	$1	$45	$16	$14	$87	$147	$12	$1	$1	$2
621610	$29	$29	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
621910	$38	$38	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
622110	$16	$16	$117	$78	$1	$23	$8	$7	$45	$76	$6	$1	$1	$1
622210	$13	$13	$100	$67	$7	$231	$81	$14	$90	$151	$60	$6	$6	$2
622310	$14	$14	$107	$71	$1	$20	$7	$6	$40	$67	$5	$1	$1	$1
623110	$26	$26	$191	$128	$2	$62	$22	$19	$121	$203	$16	$2	$2	$2
623210	$34	$34	$252	$168	$12	$387	$136	$24	$151	$254	$100	$10	$10	$4
623220	$29	$29	$215	$143	$7	$228	$80	$14	$89	$149	$73	$7	$7	$2
623311	$31	$31	$233	$155	$2	$76	$27	$24	$149	$250	$20	$2	$2	$2
623312	$25	$25	$188	$126	$2	$62	$22	$19	$121	$204	$16	$2	$2	$2
623990	$29	$29	$216	$144	$2	$61	$22	$19	$120	$201	$16	$2	$2	$2
624110	$30	$30	$222	$148	$2	$57	$20	$18	$112	$188	$15	$1	$1	$1
624120	$26	$26	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
624190	$25	$25	$186	$124	$2	$49	$17	$15	$96	$162	$13	$1	$1	$1
624210	$27	$27	$200	$133	$2	$50	$17	$16	$97	$163	$13	$1	$1	$1
624221	$23	$23	$173	$115	$2	$49	$17	$15	$97	$162	$11	$1	$1	$1
624229	$18	$18	$137	$92	$2	$50	$17	$16	$97	$163	$9	$1	$1	$1
624230	$24	$24	$180	$120	$1	$45	$16	$14	$88	$149	$12	$1	$1	$1
624310	$18	$18	$136	$90	$1	$38	$13	$12	$75	$126	$10	$1	$1	$1
Fire EMT	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Source: OSHA, 2022.
Note: A $0 indicates zero cost for these establishments.

Section VI. Federal Rules That May Duplicate, Overlap, or Conflict with the Draft Standard

The Regulatory Flexibility Act (RFA) requires that the agency's initial regulatory flexibility analysis identify, "to the extent practicable, [] all relevant Federal rules which may duplicate, overlap or conflict with the proposed rule." 5 U.S.C. § 603(b)(5).[44] OSHA has identified several federal rules and guidelines that may generally address workplace violence against employees in the healthcare and social assistance sector. Below, the agency discusses whether these rules and guidelines would duplicate, overlap, or conflict with the draft regulatory language. While some federal rules may have overlapping requirements, OSHA did not identify any rules that were in conflict. The agency therefore believes that no federal rules would prevent compliance with the draft standard.

Other Federal Rules

The first set of federal rules or guidelines that OSHA identified are regulations promulgated by the Department of Veterans Affairs (VA). These VA regulations apply to facilities operated by the Veterans Health Administration (VHA), which is the nation's largest health care system, employing more than 367,200 full-time health care professionals and support staff at 1,293 health care facilities, including 171 VA Medical Centers and 1,112 outpatient sites (VHA outpatient clinics). While there may be some overlap between VA regulations and OSHA's draft standard, OSHA is not aware of any conflicts and the VA regulations would not obviate the need for OSHA's draft standard because the latter also covers a wide range of workplaces not subject to VA regulations.

VA regulations require various types of facilities to provide a physical environment that protects the health and safety of patients, employees, and the public. *See, e.g.*, 38 C.F.R. § 51.200 (nursing homes); 38 C.F.R. § 59.130(a) (state homes). It is OSHA's understanding that the vast majority of facilities subject the VA regulations are not operated by employers who qualify as "small entities" for the purpose of SBREFA. The VA regulations are generalized requirements, and there are no specific requirements that duplicate, overlap, or conflict with the requirement in OSHA's draft standard for covered employers to develop and implement workplace violence prevention programs, conduct hazard assessments, implement control measures (including engineering and work practice controls to eliminate or minimize employee exposure to hazards), implement a training program, and investigate and record workplace violence incidents.

In addition, one VA regulation requires employees to report each work-connected injury, accident, or disease they suffer. *See* 38 C.F.R. § 0.735–12(a)(2). Employees must also report actual or possible violations of the law related to public safety and sexual assault with the VA. *See* 38 C.F.R. §§ 1.201, 1.203. While this reporting requirement slightly overlaps with and duplicates the requirement in OSHA's draft standard for covered employers to implement and maintain a violent incident reporting system, these requirements do not conflict.

[44] Separately, the OSH Act does not apply to "working conditions" of workers with respect to which another federal agency has "exercise[d] statutory authority to prescribe or enforce standards or regulations affecting occupational safety or health." 29 U.S.C. § 653(b)(1).

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 directed the VA to develop and implement a comprehensive policy on the reporting and tracking of sexual assault and other public safety incidents that occur at each VA medical facility. *See* 38 U.S.C. § 1709(a). VHA Directive 2012-026, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities implemented this unified policy.

The VHA Directive expired on February 28, 2015, and has not been updated. In 2015, however, the VHA implemented the Disruptive Behavior Reporting System, which allows all VHA staff to report disruptive behavioral events. *See* 38 C.F.R. § 17.107. While there may be some overlap or duplication between this requirement and OSHA's draft rule, there would be no conflict because OSHA's draft standard also requires employers to implement and maintain a violent incident reporting system and establish and implement policies and procedures for effective communication of a patient/client/resident's history or potential for violence.

Finally, the VHA issued VHA Directive 5019.01, VHA Workplace Violence Prevention Program, on August 23, 2021, which requires the development and implementation of a VHA Workplace Violence Prevention Program (WVPP) in VA medical facility workplaces. In many ways, Directive 5019.01 does not so much establish new requirements for VHA facilities, but rather pools disparate pre-existing requirements that have been in effect for many years, to one uniform source, along with guidance, to aid with compliance with these requirements in VHA facilities. The policy for implementing the WVPP is supported by several established guidelines on workplace violence, including the requirements from the Joint Commission (discussed below) and OSHA. Similar to the draft regulatory text OSHA has provided, the VHA Directive requires employee education, data collection and analysis, behavioral threat assessment and management, and communication protocols.

The WVPP under the VHA Directive has several specific components, including the Prevention and Management of Disruptive Behavior Program as part of the mandatory training of all VHA personnel in workplace violence prevention; the Disruptive Behavior Reporting System to report disruptive or violent events; the Workplace Behavioral Risk Assessment that provides local workplace violence prevention programs with estimates of workplace violence risk exposure specific to the facility; the behavioral threat assessment to estimate the risk an individual poses; behavioral threat management based on the findings of the individualized behavioral threat assessment; and pathways for communication of the threat management recommendations.

VHA Directive 5019.01, Appendices A-F.

The Directive addresses governance of the WVPP in VA medical facility workplaces only. While some of these components are similar to the types of measures that are included in the draft regulatory text, OSHA does not believe that any of the provisions in the draft regulatory texts are in direct conflict with the VHA Directive.

There may be overlapping elements between the VHA Directive and the draft regulatory text that OSHA has provided in this package. However, as noted above, this Directive applies to employees in VA medical facilities only and not to the healthcare and social assistance industry as a whole. Further, OSHA has enforcement mechanisms that the VHA does not have, such as responding to complaints, conducting inspections, and issuing notices of unsafe and unhealthful

working conditions. The joint effect of an OSHA standard and the VHA Directive can reasonably be expected to result in better compliance than either one alone. Thus, such a rule would complement the VHA Directive and would be likely to improve overall compliance with workplace violence prevention practices in VA workplaces that would be covered by the draft standard.

The second set of federal rules or guidelines that OSHA identified as potentially duplicative, overlapping, or conflicting are regulations promulgated by the Centers for Medicare and Medicaid Services (CMS). CMS regulations have a much narrower scope than OSHA standards, as they do not cover providers that do not accept or collect payment through Medicare or Medicaid. However, they do cover health care providers that accept or collect payment through Medicare or Medicaid, including hospitals, nursing homes, home health care (of kinds covered by Medicare), and ambulatory care facilities.

CMS regulations require various types of facilities to provide a physical environment that protects the health and safety of patients, employees, and the public. *See, e.g.*, 42 C.F.R. § 418.110(c) (hospice care facilities that provide inpatient care in their own facilities); 42 C.F.R. § 483.90 (long term care facilities); 42 C.F.R. § 485.62 (comprehensive outpatient rehabilitation facilities); 42 C.F.R. § 485.918(e)(1) (Community Mental Health Centers).

These regulations are general and do not require the implementation of any specific controls. There would be no conflict between OSHA's draft standard and these CMS regulations because OSHA's draft standard requires employers to use engineering, administrative, and work practice controls, as well as personal protective equipment to eliminate or minimize employee exposure to hazards. OSHA's draft standard therefore provides specific requirements that are consistent with the more general CMS requirements. Facilities under OSHA's jurisdiction that are complying with the CMS requirements may already be meeting certain requirements contained in the draft standard.

CMS regulations establish standards for the use of restraints or seclusion to ensure the safety of patients, employees, and others in various types of facilities. *See, e.g.*, 42 C.F.R. § 482.13(e) (hospitals); 42 C.F.R. § 483.450(d) (intermediate care facilities for individuals with intellectual disabilities); 42 C.F.R. §§ 483.350–376 (psychiatric residential treatment facilities for individuals under age 21). While OSHA's draft standard references the use of restraints, it does not overlap, duplicate, or conflict with these CMS regulations because OSHA's draft standard simply requires employers who use restraint methods to have standard operating procedures for the appropriate use of restraints by employees, in accordance with federal, state, and local laws.

The CMS requirements provide specific standards for the appropriate use of restraints that may be incorporated into the policies and procedures required in OSHA's draft standard and are therefore consistent with OSHA's draft standard. Facilities under OSHA's jurisdiction that are complying with the CMS requirements may already be meeting certain requirements contained in the draft standard.

CMS regulations for psychiatric residential treatment facilities for individuals under age 21 require staff to document injuries to staff resulting from an emergency safety intervention (such as restraints or seclusion), and to meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries. 42 C.F.R. § 483.372(c)–(d).

These regulations also require staff in these facilities to have ongoing education, training, and demonstrated knowledge of: (1) techniques to identify behaviors, events, and factors that may trigger emergency safety situations; (2) nonphysical intervention skills like de-escalation techniques; and (3) safe use of restrain and seclusion. 42 C.F.R. § 483.376(a)(1)—(3).

OSHA's draft standard requires employers to implement and maintain a violent incident reporting system and to conduct hazard assessments and is therefore consistent with the CMS requirements. Likewise, OSHA's draft standard would also require training on, among other things, how to recognize threatening behaviors and de-escalation techniques. While there may be slight overlap with the CMS regulations related to employee injuries in these facilities, the requirements do not conflict. Facilities under OSHA's jurisdiction that are complying with the CMS requirement may already be meeting certain requirements contained in the draft standard.

One CMS regulation requires intermediate care facilities for individuals with intellectual disabilities to provide a staff-to-client ratio of at least 1 to 3.2 for clients who are aggressive, assaultive, or security risks. *See* 42 C.F.R. § 483.430(d)(3)(i). There would be no conflict between OSHA's draft standard and this CMS regulation because OSHA's draft standard does not require a specific staff-to-patient ratio; rather, it requires employers to assign or place sufficient numbers of staff to reduce workplace violence hazards. The CMS requirement provides a specific staffing standard for a particular type of facility and is a ratio related to patient care, not staff safety. There is no conflict between this requirement and OSHA's draft standard, and some facilities under OSHA's jurisdiction that are already complying with the CMS requirement may be meeting certain requirements contained in the draft standard.

Hospitals and long-term care facilities are required by CMS to develop and maintain an emergency preparedness plan that is based on both a facility-based and community-based risk assessment, using an all-hazards approach. *See* 42 C.F.R. §§ 482.15(a) (hospitals), 483.73(a) (long-term care facilities). These facilities must develop and maintain an emergency preparedness training and testing program based on the plan, risk assessment, and policies and procedures. *See* 42 C.F.R. §§ 482.15(d) (hospitals), 483.73(d) (long-term care facilities). This plan and the corresponding training, like OSHA's draft proposed hazard assessment and training requirements, are performance-oriented and do not conflict with each other. Given the performance-oriented nature of these requirements, OSHA anticipates that employers that have to comply with these CMS requirements could develop a single plan that complies with both sets of requirements.

All Medicare and Medicaid providers and suppliers are required by CMS to develop and maintain a comprehensive emergency preparedness plan that is based on both a facility-based and community-based risk assessment, using an all-hazards approach. *See* 42 C.F.R. §§ 482.15(a) (hospitals), 483.73(a) (long-term care facilities). The purpose of this rule is to establish federally enforceable consistent requirements for these providers to have a plan to protect patients, staff and communities during local, state, and national natural or man-made disasters or emergencies. The required four core elements of an emergency preparedness plan are: (1) risk assessment and emergency planning (2) policies and procedures (3) communication plan, and (4) training and testing. *See* 42 C.F.R. § 494.62. The emergency preparedness rule stipulates that an all-hazards approach be used for the risk assessment, training, testing, policies, procedures, and communication plan *See* 42 C.F.R. § 494.62, § 482.15(d), 483.73(d).

There may be overlapping elements between the CMS emergency preparedness rule and the

proposed OSHA standard. The CMS rule is a non-prescriptive approach for preparing Medicare and Medicare providers and suppliers for natural and man-made emergencies. The CMS mandated facility specific assessment of emergencies may encompass man-made emergencies, including workplace violence. However, the CMS rule does not include language specific to workplace violence assessment, program implementation, and enforcement. There is a potential for overlap in the hazard assessment and training requirements in the proposed and existing rule. However, the CMS required plan and the corresponding training, like OSHA's draft proposed hazard assessment and training requirements, are performance-oriented and do not conflict with each other.

As described the proposed rule provides an enforceable standard specific to the hazard of workplace violence. In addition, the proposed OSHA standard covers facilities outside CMS jurisdiction. It is anticipated the proposed OSHA standard would enhance the successful implementation of workplace violence prevention measures identified in the CMS rule. Given the performance-oriented nature of these requirements, OSHA anticipates that employers that have to comply with these CMS requirements could develop a single plan for both sets of requirements.

OSHA has also included multiple provisions regarding assessment of workplace violence hazards specifically for home healthcare settings, particularly in Table E-1, in this draft rule. CMS also includes assessments that may identify violent behaviors in home healthcare. Specifically, the requirement for such assessments exist at 42 CFR § 484.55 Condition of participation: Comprehensive assessment of patients, which requires an Outcome and Assessment Information Set (OASIS) assessment.

The OASIS is a patient-specific, standardized assessment tool used in Medicare home health care to plan care, determine reimbursement, and measure quality of care associated with the requirements under 42 C.F.R. § 484. The purpose of the OASIS is to provide a standardized assessment tool to monitor quality of care. OASIS evaluations are conducted at the start of care, as well as in 60-day intervals or other intervals, as applicable (e.g., discharge, transfer, and change in condition, etc.), in order to monitor patient care. Assessments are typically conducted by care providers who submit scored evaluations to case managers responsible for developing a care plan to ensure continuity of care for patients served.

Various health indicator criteria are included in the evaluation, and are recorded on the Home Health Patient Tracking Sheet (Form OMB #0938-1279). Element (M1740) of the Home Health Patient Tracking Sheet is intended to document any notable observation with regard to cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (reported or observed). These symptoms may include use of threats, physical aggression, throwing objects, punching, dangerous maneuvers with wheelchair or other objects, etc., as indicated on Form OMB #0938-1279.

Although the CMS requirements under 42 CFR § 484 – *Home health services* may in certain circumstances involve the assessment of patients in home healthcare settings for their propensity for violent behaviors, OSHA does not find the language in this draft regulatory text to be wholly duplicative. First, the intent of these two assessments are different. The CMS assessment under §

484.55 is primarily focused on patient healthcare needs and the limited portion relevant to potential violent behavior is intended to serve as an indicator of change in patient status or shift in patient acuity (e.g., functional impairment level is low, medium, or high), largely for the purpose of patient safety and monitoring quality of care. Conversely, the draft regulatory language OSHA has included in this package is intended to be focused on *worker safety*, and the assessment ties directly to specific hazard controls and other elements of a comprehensive workplace violence prevention program (WVPP).

Second, the requirements under 42 C.F.R. § 484 are intended to specifically document behaviors of the *patient* as may pertain to propensities for violent behavior. It is the intent of OSHA's draft regulatory language to more broadly apply to other aspects of the home health environment as well, including the geographical area/neighborhood of the site of care, patient family members, or other members of a household or other site of care. For these reasons, OSHA has concluded that the draft regulatory text included in this package does not wholly duplicate the requirements under 42 C.F.R. § 484.55. To the extent that there is any duplication between the information reported in the OASIS assessment or other information obtained as part of the CMS-required assessment, OSHA's draft standard could conceivably permit the employer to include a copy of the relevant portion of the CMS assessment and reference it as part of the OSHA assessment.

None of CMS's other regulations conflict with OSHA's draft standard; rather, to the extent that any requirements are similar, OSHA anticipates that an OSHA standard would reinforce and strengthen compliance at all healthcare and social assistance facilities covered by the draft standard. Moreover, OSHA has enforcement mechanisms that CMS does not have (*e.g.*, responding to complaints, conducting random unannounced inspections, and issuing citations and proposed penalties). CMS regulations, on the other hand, establish the terms of a contractual or quasi-contractual agreement between CMS and a provider. The repercussions for violating a contractual agreement "stand[] in sharp contrast to the civil and criminal penalties provided for in the [OSH] Act." *Cf. Ensign-Bickford Co. v. OSHRC*, 717 F.2d 1419, 1421 n.3 (D.C. Cir. 1983) (holding an agency regulates working conditions within the meaning of section 4(b)(1) of the OSH Act only if it "implements [a] regulatory apparatus necessary to replace those safeguards required by the Act.").

The Joint Commission

The Joint Commission is an independent non-profit organization that accredits and certifies more than 22,000 healthcare organizations and programs in the United States, including hospitals and healthcare organizations that provide ambulatory and office-based surgery, behavioral health, home healthcare, and laboratory and nursing care center services. Through this accreditation, providers are afforded the right to participate in CMS funding streams. The Joint Commission's primary role is to certify healthcare facilities as meeting the necessary criteria for the best patient care. As a private, non-profit organization, it does not mandate participation from any healthcare facility.

The Joint Commission recently published new requirements for the prevention of workplace violence in all Joint Commission-accredited hospitals in the Environment of Care (EC.02.01.01, EC.04.01.01), Human Resources (HR.01.05.03), and Leadership (LD.03.01.01) chapters. These requirements will be effective January 1, 2022. The new Joint Commission requirements for the

prevention of workplace violence include an annual worksite analysis, assessment of risks, reporting processes, development of policies and procedures to prevent workplace violence, and education and training interventions such as de-escalation (R^3 Report - Requirement, Rationale, Reference, 2021). OSHA does not believe that any action by the agency to promulgate a standard on workplace violence in healthcare and social assistance would conflict with the current accreditation standards of the Joint Commission.

Some overlapping elements may exist between the Joint Commission requirements and the regulatory text that OSHA has provided in this package. However, compliance with the Joint Commission requirements is generally validated through periodic accreditation surveys of the employer's facility by the Joint Commission. The Joint Commission requirements establish the terms of a contractual or quasi-contractual agreement between the Joint Commission, CMS, and a provider. As noted above, OSHA has enforcement mechanisms that the Joint Commission and CMS do not have. For example, OSHA can respond to complaints, conduct random unannounced inspections, and issue citations and proposed penalties. Furthermore, the Joint Commission accredits approximately 22,000 establishments, whereas the regulatory text that OSHA has provided would apply to upwards of 300,000 healthcare and social assistance-providing establishments.

Additionally, the joint effect of an OSHA standard and the Joint Commission requirements can reasonably be expected to result in better protection for workers at covered facilities than compliance with the Joint Commission requirements alone. This conclusion is borne out by the joint effect of CMS's enforcement of its infection control regulations alongside OSHA's enforcement of its existing Bloodborne Pathogens standard – a regime that has been in place for thirty years. The Bloodborne Pathogens standard, which has existed alongside the CMS regulations since its promulgation, led to significant declines in bloodborne diseases among healthcare workers. *See* 29 C.F.R. 1910.1030. Thus, such a rule would complement the Joint Commission requirements and would likely improve overall compliance with workplace violence prevention practices.

OSHA Standards

OSHA does not have any standards that already cover workplace violence against employees in the healthcare and social assistance sector.

References

CMS (2022) Home Health Patient Tracking Sheet (Form OMB #0938-1279) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-D_All-Items_final.pdf

The Joint Commission. (2021). *Workplace violence prevention: R3 report: Requirement, rationale, reference.* (No. 30).The Joint Commission.

Veterans Hospital Administration. (2021). *VHA workplace violence prevention progra*(Directive No. VHA Directive 5019.01).VHA

Section VII. Regulatory Alternatives and Options

This section describes the regulatory alternatives and options OSHA is considering.[45] Table 1 summarizes the annualized costs for the potential standard, as calculated in Section V, using a three percent discount rate. Some of the regulatory alternatives and options discussed below would alter the scope, and thus the number of affected employers and employees, while others would expand, modify, or eliminate specific requirements that OSHA is considering.

Table 1. Total Annualized Costs by Rule Section ($2019)

Draft Rule Section	Total Annualized Cost, millions, $2019, 3% discount rate
Part C – Workplace Violence Prevention Plan	$65.1
Part D – Workplace Hazard Assessment	$63.6
Part E – Controls	$104.8
Part F – Training	$908.8
Part G – Violent Incident Reporting	$73.5
Total	$1,215.9

Source: OSHA, 2021.
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

Notable from Table 1 is the fact that the largest portion of total costs is the element of workplace violence prevention training. Of the estimated cost total of $1.22 billion, training accounts for $909 million, or approximately 75 percent of total costs.

Education and training are key elements of a workplace violence protection program, and help ensure that all staff members are aware of potential hazards and how to protect themselves and their coworkers through established policies and procedures. Such training can be part of a broader type of instruction that includes protecting patients and clients (such as training on de-escalation techniques). This training can: (1) help raise the overall safety and health knowledge across the workforce, (2) provide employees with the tools needed to identify workplace safety and security hazards, and (3) address potential problems before they arise and ultimately reduce the likelihood of workers being assaulted.
In this section, OSHA presents a number of regulatory alternatives and options. OSHA welcomes suggestions from the SERs regarding these regulatory alternatives and options, as well

[45] "Alternatives," as referenced under section 603(c) of the Regulatory Flexibility Act (RFA), "accomplish the stated objectives of applicable statutes that minimize any significant economic impact of the proposed rule on small entities." For the purposes of this PIRFA, the term "option" is used to describe a potential scope change or substitute measure that does not meet the RFA definition for "alternative."

The designation of "alternative" or "option" is preliminary. OSHA will update the preliminary designation of whether a textual change to the regulatory framework is an alternative or option following the SBAR Panel Meetings involving SER participation.

as additional alternatives or options the agency should consider. The total costs of the potential regulatory alternatives and options addressing the provisions, where quantified, are summarized in Table 2 and discussed in the text, with annualized costs calculated using a three percent discount rate.

Table 2. Annualized Costs for Regulatory Alternatives, Options, and Sensitivity Tests ($2019)

Regulatory Alternative, Option, or Sensitivity Test	Change in Annualized Cost ($) (3%)	Percent Change in Annualized Cost	Annualized Cost, Alternative (3%)
Scope			
1. Standard applies to "patient care" only – not "patient contact"; Exempt patient contact employees from the scope of the rule. (Scope Alternative #1)	($23,516,110)	-1.93%	$1,192,336,875
2. Within Social Assistance sectors, limit the scope to include only NAICS 6241, Individual and Family Services. (Scope Alternative #2)	($23,997,530)	-2.0%	$1,191,855,456
3. Eliminate non-fixed location sectors from the standard (Emergency Response, Home Healthcare, and Field-Based Social Assistance Services) (Scope Alternative #3)	($285,391,219)	-23.5%	$930,461,766
4. Expand scope to include locations where healthcare services are provided in correctional facilities and educational settings. (Scope Option #1)	$30,155,251	2.48%	$1,246,008,236
C. WVPP			
5. Staggered periodicity of annual review (biennially or triennially (cost change shown for biennial estimate) vs. annually) (WVPP Alternative #1)	($22,037,560)	-1.8%	$1,193,815,425
D. Hazard Assessment			
6. Change workplace violence incident records review for annual hazard assessments from three years of data to just one year or two years of incident data. (Hazard Assessment Alternative #1)	($5,663,316)	-0.5%	$1,210,189,669
7. Employers would only assess OSHA-defined high-risk service areas and not be expected to identify additional high-risk services areas based on their experiences and recordkeeping (Hazard Assessment Alternative #2)	($49,264,063)	-4.1%	$1,166,588,922
8. Change the definition of high-risk service area -- No requirement for employers to conduct establishment-wide hazard assessments based on OSHA's pre-determinations of high-risk service areas; hazard assessments would be directed to employer-defined high-risk service areas assessments only (Hazard Assessment Alternative #3)	($157,322,225)	-12.9%	$1,058,530,760
E. Hazard Controls			
9. Require only hazard assessment, development of a plan, and provision of training (Hazard Controls Alternative #1)	($101,667,773)	-8.4%	$1,114,185,212
10. Require that employers implement administrative/work-practice controls only -- No requirement for employers to implement environmental or engineering controls (Hazard Controls Alternative #1a)	($93,996,083)	-7.7%	$1,121,856,902
11. Require that employers implement a limited set of environmental or engineering controls (Hazard Control Alternative #1b)	Not quantified		
12. Remove requirement for all employers to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #2)	($9,965,590)	-0.8%	$1,205,887,395

Regulatory Alternative, Option, or Sensitivity Test	Change in Annualized Cost ($) (3%)	Percent Change in Annualized Cost	Annualized Cost, Alternative (3%)
13. Remove requirement for small entities to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #3)	($1,047,187)	-0.1%	$1,214,805,798
F. Training			
14. Remove annual training; retain initial training (Training Alternative #1)	($755,090,859)	-62.1%	$460,762,126
15. Require annual training for a more limited subset of employees (e.g., those with direct-patient/client/resident care and violent incident response duties only) (Training Alternative #2)	($19,650,597)	-1.6%	$1,196,202,388
16. Reduce the expected number of training hours (Training Alternative #3)	($454,405,330)	-37.4%	$761,447,655
17. Require refresher training every 3 years instead of annually (Training Alternative #3)	($510,796,039)	- 42.0%	$705,056,946
17a. Require refresher training every 2 years instead of annually (Training Alternative #3a)	($419,738,961)	-34.5%	$796,114,024
18. Require 24 hours of training for small facilities (≤2 employees on site) (Training Option #1)	$14,139,424	1.2%	$1,229,992,409
19. Reduction of expectation of training length for the most advanced level of employee workplace violence prevention training (Training Sensitivity Test #1)	($19,848,474)	-1.6%	$1,196,004,511
G. Violent Incident Investigation & Recordkeeping			
20. Require post-incident investigations only for workplace violence incidents involving physical assault (Incident Investigation Alternative #1)	($13,729,830)	-1.1%	$1,202,123,156
21. Require post-incident medical and psychological evaluations and treatment			
(a) For WPV Recordable, Lost-Work Incidents (Post-incident Evaluations Options #1)	$108,746,045	8.9%	$1,324,599,030
(b) For WPV Recordable, Non-Lost-Work Incidents (Post-incident Evaluations Options #2)	$231,641,450	19.1%	$1,447,494,435
(c) For Total Recordable WPV Incidents (Post-incident Evaluations Options #3)	$340,387,495	28.0%	$1,556,240,480
22. Effective Date of the Standard Alternative #1: Extension of compliance date for requirements in paragraphs (e) Control Measures and (f) Training or any other provisions in this draft standard might require more than six months to come into compliance.			
23. General Alternative: OSHA opts to take no action on this draft standard on Prevention of Workplace Violence in Healthcare and Social Assistance, and continues to address workplace violence hazards in healthcare and social assistance solely through use of the General Duty Clause.			

Source: OSHA, 2023.

Alternatives and Options

This section includes alternatives that OSHA preliminarily believes may meet the agency's statutory objectives, be feasible, and reduce the burden on small entities. Consistent with the requirements of section 603(c) of the Regulatory Flexibility Act (RFA), OSHA seeks to solicit feedback through the SBREFA process that will assist the agency in the decision-making process and help the agency clarify which of these alternatives meet the OSH Act's requirements.

Paragraph (b) Scope:

Scope Alternative #1: **Standard applies to "patient care" only – not "patient contact"; Exempt patient contact employees from the scope of the rule**

Throughout OSHA's current draft of this regulatory text, OSHA addresses employees that are defined as those with "direct patient/client/resident contact" and those who provide "direct patient/client/resident care".

- *Direct patient/client/resident contact employees are defined as those that perform support work that requires them to be in patient care areas. Such work includes environmental services, engineering services, laundry services, meal delivery, information technology, and others. For purposes of SBREFA, OSHA also considers security staff to belong in this category.*

- *Direct patient / client / resident care employees are defined as those having job duties that involve the delivery of healthcare services or social assistance services with hands-on or face-to-face contact with patients/clients/residents. Employees who provide direct patient/client/resident care include nurses, physicians, nursing assistants, patient care assistants, technicians, and other healthcare workers, social workers visiting client homes, as well as employees providing emergency medical services.*

Taken together, the total cost for coverage of both of these sets of employees totals $1.22 billion.

In general, workers performing duties in the direct patient/client/resident *care* category experience higher incidents of workplace violence than those in the *contact* category. Job category can impact risk of WPV because it determines the frequency and type of contact an employee will have with patients. Employees in positions providing patient care are likely at higher risk of WPV because they spend more time interacting closely with patients and often perform more intimate care tasks. While some patient/client/resident contact duties involve significant time interacting with patients or clients and therefore carry risk of workplace violence, on average they experience fewer workplace violence incidents than those providing more intensive care, likely because the patient/client/resident contact duties typically involve less time interacting in close proximity with patients and clients than patient/client/resident care duties. Within the category of care providers, research shows that

> healthcare employees in positions providing the most frequent and prolonged patient care, such as nurses, nursing aides, and home care aides, experience WPV at higher rates than those in positions requiring less frequent or prolonged patient care and/or contact, such as physicians. For example, in a survey of WPV in VHA medical centers from 1990-1991, the rate of injury due to assaultive behavior per 1,000 employees was 71.8 for nursing assistants, 34.6 for licensed practical nurses (LPNs), 22.5 for registered nurses (RNs), and 4.5 for physicians (Lehmann, et al. 1999).

Taking this into consideration, one alternative for which OSHA seeks input from SERs is on narrowing the scope of the standard to apply only for employees who categorized as direct patient/client/resident care providers (e.g., nurses, physicians, nursing assistants, patient care assistants, technicians, and other healthcare workers, social workers visiting client homes, as well as employees providing emergency medical services).

This alternative would only cover employees responsible for direct patient/client/resident care, that involve hands-on or face-to-face interaction with patients or clients. Employees who provide support work (i.e., housekeeping, maintenance, meal delivery, engineering, laundry services, etc.) would not be covered. If OSHA were to cover only these direct patient/client/resident care, this would result in a cost reduction of $23.5 million, a 1.9 percent reduction in costs in relation to the default (baseline) cost total of $1.22 billion for the entire standard. Security employees, who for the purposes of SBREFA are designated as patient contact employees, would not be covered under this proposed alternative. For the 201,698 employers affected by this regulatory alternative, the cost reduction would be approximately $116.59 per employer.

OSHA views this alternative with some degree of disfavor because the agency believes that all employees that are exposed to any measure of Type-II workplace violence need to be protected from the hazard. Additionally, studies show that certain kinds of workers, such as security personnel, who engage in patient/client/resident contact still face high rates of workplace violence (Lehmann, et al. 1999). Furthermore, assuming that patient/resident/contact employees may account for approximately 20 percent of all WPV injuries (as discussed on page 52, in this case, that would amount to over 3,000 injuries per year severe enough to cause days away from work that would be left unaddressed. However, OSHA welcomes feedback on this regulatory alternative. OSHA also seeks input on whether the agency should include both direct patient/client/resident care AND direct patient/client/resident contact employees in the scope of this potential standard for some or all provisions. OSHA also welcomes comment on other potential alternatives for excluding some of the employees currently covered by the draft standard and whether there would be alternative protections for the employees not covered by the draft standard.

Scope Alternative #2: **Within Social Assistance sectors, limit the scope to include only NAICS 6241, Individual and Family Services.**

Social assistance is a tremendously diverse industry sector covering a broad scope of services including Individual and Family Services (NAICS 6241); Community Food and Housing, and Emergency and Other Relief Services (NAICS 6242); and Vocational Rehabilitation Services (NAICS 6243). [46] The descriptions of NAICS 6241, 6242, and 6243 in this section are from United States Census Bureau, North American Industry Classification System, 2022 NAICS, https://www.census.gov/naics/ (accessed February 4, 2022).

- NAICS 6241 – Individual and Family Services – "This Industry group comprises establishments primarily engaged in providing nonresidential social assistance to children and youth, the elderly, persons with disabilities, and all other individuals and families."

- NAICS 6242 – Community Food and Housing, and Emergency and Other Relief Services – "This industry group comprises establishments primarily engaged in one of the following: (1) collecting, preparing, and delivering food for the needy; (2) providing short-term emergency shelter, temporary residential shelter, transitional housing, volunteer construction or repair of low-cost housing, and/or repair of homes for individuals or families in need; or (3) providing food, shelter, clothing, medical relief, resettlement, and counseling to victims of domestic or international disasters or conflicts (e.g., wars)."

- NAICS 6243 – Vocational Rehabilitation Services – "This industry comprises (1) establishments primarily engaged in providing vocational rehabilitation or habilitation services, such as job counseling, job training, and work experience, to unemployed and underemployed persons, persons with disabilities, and persons who have a job market disadvantage because of lack of education, job skill, or experience and (2) establishments primarily engaged in providing training and employment to persons with disabilities. Vocational rehabilitation job training facilities (except schools) and sheltered workshops (i.e., work experience centers) are included in this industry."

BLS data indicate elevated rates of workplace violence across these social assistance sectors compared with the average for general industry. For example, whereas the average rate for workplace violence injuries for all industries in 2019 was 2.0 per 10,000 FTEs, the incidence rates for NAICS 6241 - Individual and Family Services, NAICS 6242 - Emergency and Other Relief Services, and NAICS 6243 - Vocational Rehabilitation Services were, respectively, 12.4, 8.9, and 21.8. (BLS Table R-8, 2019)

OSHA recognizes that the sector of social assistance most closely aligned with that of the healthcare industry, in terms clientele, job duties, exposure frequency, and overlap with

[46] Also within the Social Assistance sector (NAICS 624) is NAICS 6244 – Child Day Care Services. OSHA has made a preliminary determination to exclude child day care services from the scope of the regulatory framework, as indicated within the scope of the draft regulatory text.

healthcare services, may be that of NAICS 6241 - Individual and Family Services, which includes adult day care centers (elderly, disabled, etc.), non-medical home care of the elderly, disability support groups, companion services for elderly or disabled clients, and senior citizen centers. NAICS 6241 also encompasses alcoholism and drug addiction counseling, self-help organizations, hotline centers, counseling services, crisis centers (for rape, suicide, etc.), support group services and other individual and family social services. Finally, NAICS 6241 also includes adoption agencies, youth centers (except recreational only), foster care placement services/agencies, and child welfare services.

OSHA seeks feedback on the applicability of the draft standard to NAICS 6242 and 6243. These sectors are similar to healthcare providers in terms of prolonged close exposure between clients and providers, but OSHA recognizes that employers in this industry may follow operational models and handle social issues that may be significantly dissimilar to the operational models and issues in traditional healthcare settings. OSHA is interested to hear from SERs about how effectively the draft regulatory text (which is directed largely toward the healthcare sector) could be effectively applied in settings that are more directed to community food services, temporary shelters, other community housing services, job counseling, job training, work experience, and similar services.

OSHA is concerned about this alternative, however, because the rates of violence are either similar or even higher in 6242 and 6243 than in 6241, and these workers also need protection from workplace violence. As such, in this case, that would amount to over 670 injuries per year severe enough to cause days away from work that would be left unaddressed. Nonetheless, OSHA also welcomes feedback from SERs on whether the totality of establishments that operate under NAICS 624 should be covered in the scope of this draft standard. OSHA also understands that social assistance services do not always fit into such distinct categories, and that there may be considerable overlap between the NAICS sectors described above, and the services that are offered to social assistance clients through social assistance establishments.

If OSHA were to cover only these NAICS 6241 Individual and Family Services employers within Social Assistance, and to exclude other subsectors of NAICS 624, this would result in a cost reduction of $24.0 million, equivalent to a 2.0 percent change in annualized cost.

Scope Alternative #3: **Eliminate non-fixed location sectors from the standard (Emergency Response, Home Healthcare, and Field-Based Social Assistance Services)**

OSHA's proposed scope in this draft regulatory text covers a diverse range of sectors of the healthcare and social assistance industry:

> *(i) Hospitals, including emergency departments;*
> *(ii) Psychiatric hospitals and residential behavioral health facilities;*

(iii) Ambulatory mental healthcare and ambulatory substance abuse treatment centers;
(iv) Freestanding emergency centers;
(v) Residential care facilities;
(vi) Home healthcare;
(vii) Emergency medical services; and
(viii) Social assistance (excluding child day care centers).

Exhibit 1, below, presents, by four-digit NAICS categories within private industry, the 2019 lost-workday incidence rates for two injury events of concern to OSHA: (1) intentional injury by other person and (2) unintentional injury from physical contact while restraining.

Exhibit 1. Lost Work-Day Incident Rates (incidents per 10,000 FTEs)- Private industry

NAICS	NAICS Description	Intentional Injury by Other Person	Injured by physical contact while restraining--unintentional	Total WPV Lost-Work Day Rate
621112	Offices of Physicians, Mental Health Specialists	26.6	0.0	26.6
621300	Offices of other health practitioners	10.5	2.6	13.1
621420	Outpatient Mental Health and Substance Abuse	3.9	0.4	4.3
621493	Freestanding Ambulatory Surgical, Emergency	3.9	0.4	4.3
621610	Home Health Care Services	4.1	-	4.1
621910	Ambulance Services	3.4	2.2	5.6
622110	General Medical and Surgical Hospitals	9.7	2.4	12.1
622210	Psychiatric and Substance Abuse Hospitals	124.9	42.8	167.7
622310	Specialty Hospitals (excl. Psychiatric, Substance)	12.8	3.9	16.7
623110	Nursing Care Facilities (Skilled Nursing Facilities)	14.9	0.3	15.2
623210	Residential Intellectual, Developmental Disability	41.7	11.5	53.2
623220	Residential Mental Health and Substance Abuse	41.7	11.5	53.2
623311	Continuing Care Retirement Communities	8.5	0.7	9.2
623312	Assisted Living Facilities for the Elderly	8.5	0.7	9.2
623990	Other Residential Care Facilities	61	29	90.0
624110	Child and Youth Services	29.2	6.9	36.1
624120	Services for Elderly and Persons with Disabilities	14.7	0.5	15.2
624190	Other Individual and Family Services	7.6	1.1	8.7
624210	Community Food Services	7.5	-	7.5
624221	Temporary Shelters	11.8	-	11.80
624229	Other Community Housing Services	11.8	-	11.80
624230	Emergency and Other Relief Services	7.5	-	7.50
624310	Vocational Rehabilitation Services	17	1.7	18.70
	Firefighter-EMTs	2	1.3	3.3

Source: OSHA, 2022, based on BLS (2021)
Note: A "-" means the statistic does not meet BLS standards for publication (see https://www.bls.gov/opub/hom/soii/presentation.htm, Publication guidelines for SOII estimates. OSHA assigned these case rates a value of zero.

The total cost for including all of these sectors is $1.2 billion. Many of these industry sectors typically operate within a facility or establishment-based institutional setting; however, some employees in these sectors, including Emergency Medical Services, Home Healthcare, and Field-Based Social Assistance Services, tend to work outside of a fixed location within environmental settings that may be more difficult to control. Although OSHA is concerned about not covering workers in sectors that face an elevated risk of workplace violence, it recognizes that it may be harder for these employers to comply with the proposed standard. These employees experience on the order of 2,900 WPV-related injuries per year severe enough to cause days away from work.

OSHA requests feedback on an alternative that would remove these field-based sectors -- Emergency Medical Services, Home Healthcare, and Field-Based Social Assistance Services -- from the scope of the draft regulatory text, and instead focus the potential regulation on the establishment-based operations (i.e., service center, hospital) where employers have more direct control of the work environment. Removing these three sectors from the scope would result in a cost reduction of $285.4 million and a percent change of annualized cost of -23.5 percent.

Scope Option #1: **Expand scope to include locations where embedded healthcare services are provided in correctional facilities and educational settings**

Under this option, locations with embedded healthcare services in both educational and correctional settings, which are not currently covered by the draft standard, would be included in the scope of the standard. OSHA is interested to receive feedback and/or receive any supporting data from SERs with experience in the provision of medical services within educational support services and correctional medical services on whether OSHA should consider adding these settings to the scope of this draft standard.

The estimated additional costs under this scope alternative would amount to $46.1 million, or 3.8 percent of total annualized costs under the default scenario. For the 15,805 employers with embedded healthcare services (PCCRC employees) that would become covered by this regulatory alternative, the additional cost would be approximately $2,914 per employer.

OSHA lacks current, complete BLS SOII statistics on the severity and incidence of workplace violence in correctional health service settings, specifically, because publicly administered correctional services (NAICS 922140), are not included within the scope of the BLS Survey of Occupational Injuries and Illnesses (SOII).[47] However, the last time such data were available

[47] Privately operated correctional facilities are classified within NAICS 561210 – Facilities Support Services, a NAICS category that also includes other governmental service facilities. Thus, although BLS SOII statistics are reported for NAICS 5612, isolating the correct WPV incidence rates specifically for correctional facilities is beyond the scope of this PIRFA. Additionally, OSHA believes that some correctional medical service providers, many of whom may be contracted to provide health services within correctional facilities, report under the NAICS Code

from BLS was for 2014, at which time the incidence rate in correctional institutions generally for injuries associated with intentional injury by another person was 37.2 per 10,000 full-time employees per year. (BLS Table S8, April 2016; Ex. 0063)

OSHA has collected investigative information on workplace violence in correctional health settings. For example, in 2014, OSHA inspected one site of a large multi-state for-profit correctional health service provider in New York. In response to its 2014 inspection, OSHA issued a general duty clause citation with regard to multiple correctional health workers who experienced incidents of workplace violence during the previous year, including being threatened, punched in the face resulting in loss of consciousness, locked in a cell, splashed with unknown liquid substances, and other physical assaults. (OSHA, 2014)

The literature also indicates that correctional settings generally have a high incidence rate of workplace violence. Konda et. al. set out to gain a more complete picture of work-related injuries (in general) among correctional officers. The authors identified 113 work-related fatalities and approximately 125,200 emergency department-treated non-fatal work injuries between the years of 1999 and 2008. OSHA believes these high rates of workplace violence in correctional institutions overall indicate that workers providing health care in correctional institutions also face high rates of workplace violence since they are exposed to many of the same conditions and individuals. Fatality and injury data were collected from the BLS Census of Fatal Occupational Injuries (CFOI) and the HHS National Electronic Injury Surveillance System (NEISS-Work) and compared with data from the U.S. Census Bureau and BLS Current Population Survey (CPS). According to their analyses, the authors found that non-fatal injuries among correctional officers occurred at a rate of 300.0 per 10,000 FTEs, and that the majority of these injuries were attributed to assaults and violent acts. They also found that fatality rate was 0.27 per 10,000 FTEs (an average of 11 per year) and that assaults, violent acts, and transportation-related fatalities accounted for 80 percent of all fatalities. (Konda, 2013)

OSHA also preliminarily believes that workplace violence that affects healthcare professionals serving various educational institutions (e.g., elementary and secondary schools, junior colleges, colleges, universities, and professional schools, technical and trade schools, and other school and instruction settings) may be worth additional consideration.

OSHA lacks specific data on the extent of the incidence of workplace violence in school health service settings, however rates within certain sectors of educational settings, in general, are elevated, particularly in the elementary and secondary school sectors. The 2019 incidence rates for nonfatal occupational injuries involving days away from work per 10,000 full-time workers

621112 (Offices of Physicians, Mental Health Specialists). These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others. (U.S. Census Bureau, 2022). OSHA requests public comment from SERs on the occupational risk of workplace violence in privately operated correctional facilities and for correctional medical service providers.

per year attributable to workplace violence are:

- Educational Services: 13.3 injuries
- Elementary and Secondary Schools: 25.1 injuries
- Colleges, Universities, and Professional Schools: 1.1 injuries

(BLS Table R-8, 2019)

Although data on the risk specifically to healthcare workers in educational settings are limited, there exists a substantial body of literature on violence to teachers in schools. The risk factors confronting schoolteachers may equally apply to healthcare workers in schools, and data suggest that school counselors, social workers, nurses, and psychologists are frequently the first to see children who are sick, stressed, traumatized, act out, or hurt themselves or others." (ACLU, 2019).

According to the Report on Indicators of School Crime and Safety: 2020, during the 2015-16 school year, approximately ten percent of public school teachers reported a threat of injury by a student (IES, 2021). A higher percentage of elementary public school teachers than of secondary public school teachers reported a threat of injury (approximately eleven percent vs. nine percent) or being physically attacked (approximately nine percent vs. two percent) by a student (IES, 2021).

In a sample of 1,628 teachers in a southwestern U.S. county, 44 percent of the respondents reported that they were the target of verbal abuse and 34 percent of respondents reported noncontact physical aggression during prior year. (Moon, et al., 2020). In addition, eight percent of teachers in the sample reported at least one physical assault.

OSHA welcomes input from SERs with regard to the risks of workplace violence associated with healthcare services within correctional facilities and educational settings, and the potential need for options that include these employers within the scope of the draft standard.

Paragraph (c) Workplace Violence Prevention Program (WVPP)

WVPP Alternative #1: **Conduct review of the WVPP less frequently than an annual review (biennially or triennially vs. annually)**

In the draft regulatory text that OSHA has provided for review by SERs, employers would be required to conduct an annual review of their workplace violence prevention program (WVPP):

> *(c)(3) Review of the WVPP. The WVPP must be reviewed and updated at least annually and whenever necessary to reflect changes in the workplace, including a change in population, services provided, or the investigation of violent incidents, that indicate a need to revise policies to address employee exposure to workplace violence.*
>
> *(i) The program review must be conducted by a team consisting of management,*

non-managerial employees, and their employee representatives (if applicable).
(ii) Employers must establish and maintain written records for each review and/or update of the WVPP.
(iii) The team must evaluate records and information pertaining to the implementation and effectiveness of the WVPP.

OSHA estimates that the cost for affected entities to comply with this provision totals $39.6 million.

OSHA believes that employers conducting regular self-evaluations of their own workplace violence prevention program will result in continuous improvement to implementation. However, OSHA seeks additional information from SERs regarding whether this review could be conducted less frequently without detriment to the functioning of the program or employee safety and what information or factors would warrant such a decrease. To provide a range for cost considerations, employers conducting this review of their WVPP only once every other year (biennially) would reduce the cost by $22.0 million in comparison to annual review – with a percent change of annualized cost of -1.8 percent. For triennial reviews (every three years), the savings would be $26.8 million – with a percent change of annualized cost of -2.2 percent. The annual cost savings per affected employer would be, respectively, $133 and $109.

OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with a requirement that establishments only conduct a formal review of their workplace violence prevention plan every other year (biennially), or every three years (triennially).

Paragraph (d) Hazard assessment

Hazard Assessment Alternative #1: **Conduct hazard assessments from workplace violence incident records review for annual hazard assessments from three years of data to just one year or two years of incident data**

OSHA's draft regulatory text for prevention of workplace violence specifies that employers would be required to review three years of their workplace violence incidents as part of their annual assessment:

(d)(1) Assessment of risk factors throughout the establishment. Each employer must conduct an assessment to identify environmental and organizational risk factors throughout the establishment. The employer must:

(i) Provide an opportunity for employees to report all workplace violence incidents that occurred in the establishment in the previous three years.
(ii)Record all previously unreported workplace violence incidents in the

establishment in the previous three years.

(iii) Review all workplace violence incidents in the establishment in the previous three years.

Here OSHA presents an alternative that employers would only be required to review either one or two years of workplace violence incidents, instead of three years of workplace violence incidents, during each annual hazard assessment. OSHA is interested in how SERs assess their workplace violence and whether they have experience or other information suggesting that that some employers should be able to more quickly declassify a service area from being designated as "high-risk" by reviewing incidents occurring during a shorter period of time. If so, are there particular factors make that shorter period of time appropriate, such as the size or industry of the employer?

OSHA estimates that the savings associated with reviewing just one year of data are estimated to be $5.7 million – with a percent change of annualized cost of -0.5 percent. The savings associated with reviewing only two years of data are estimated to be $2.8 million – with a percent change of annualized cost of -0.2 percent. The annual cost savings per affected employer are, respectively, $28 and $14.

OSHA requests feedback from SERs about how they currently conduct hazard assessments and the benefits or drawbacks that may be associated with a requirement that establishments conduct a review of all workplace violence incidents, including threats of physical harm, which occurred in their establishment within the previous one or two years, instead of three, in their annual review.

Hazard Assessment Alternative #2: **Employers would only focus on OSHA-defined high-risk service areas and not be expected to identify additional high-risk services areas based on previous occurrence of workplace violence**

In the draft regulatory text, OSHA defined high-risk service areas:

> *<u>High-risk service areas</u> mean settings where there is an elevated risk of workplace violence incidents. These services and settings include emergency rooms/emergency admissions/triage areas, psychiatric care, behavioral healthcare, substance abuse treatment, home healthcare, social assistance, emergency medical services […]*

Additionally, the draft regulatory text that OSHA has provided in these materials would require employers to identify additional high-risk services areas based on previous occurrence of workplace violence in that area:

> *<u>High-risk service areas</u> mean:*

[…]and other services deemed to be of high-risk for violence by the employer. An area where a workplace violence incident has occurred in the previous three years is considered to be high-risk unless the employer has a written determination demonstrating that this designation is not appropriate.

The draft regulatory text, as currently written, would then require employers to conduct additional assessments for a variety of risk factors within these employer-defined high-risk service areas, as indicated by paragraph (d)(vi):

(d)(vi) In addition to the hazards and risk factors in (d)(1)(v), at a minimum, the employer must assess all high-risk service areas, as defined in paragraph (b) for the following risk factors:

(A) Poor illumination or areas with blocked or limited visibility;
(B) Employee staffing patterns that are inadequate to reduce workplace violence or respond to workplace violence incidents;
(C) Lack of physical barrier protection between employees and patients/visitors in areas such as admission, triage, and nursing stations;
(D) Lack of effective escape routes;
(E) Entryways where unauthorized entrance may occur, such as doors designated for staff entrance or emergency exits; and
(F) Presence of unsecured furnishings or other objects that could be used as weapons.

Under this alternative's scenario, employers would not be required to designate additional areas as high-risk based on their own establishment-level experience of workplace violence incidents. Furthermore, there would be no requirement for employers to assess for the issues outlined in paragraph (d)(vi) [e.g., poor illumination, staffing patterns, physical barriers, escape routes, unsecured furnishings, etc.] in any area not pre-determined by OSHA to be a high-risk service area. Assessments and implementation of controls associated with high-risk service areas would be required solely for the OSHA-defined high-risk service areas (emergency rooms/emergency admissions/triage areas, psychiatric care, behavioral healthcare, substance abuse treatment, home healthcare, social assistance, and emergency medical services).

If an incident occurred outside of the OSHA-defined high-risk services, the only requirement would be for recordkeeping and incident review of all incidents, without designation of high-risk service areas. Employers would still perform a facility-wide assessment but would not need to designate additional high-risk areas beyond those as defined by OSHA.

The savings associated with this approach is estimated to be $49.3 million, or $244 per affected employer – with a percent change of annualized cost of -4.1 percent.

OSHA would have significant concern with such a framework, since if an employer was experiencing incidents outside of the OSHA-defined high-risk service areas of their establishment, there would be no requirement for the employer to implement the control methods identified in paragraph (e)(3) for high-risk areas. Nonetheless, OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with such a framework.

Hazard Assessment Alternative #3: **Change the definition of high-risk service area -- No requirement for employers to conduct hazard assessments based on OSHA's pre-determinations of high-risk service areas; hazard assessments would be directed to employer-defined high-risk service areas only**

Somewhat the opposite of *Hazard Assessment Alternative #2*, *Hazard Assessment Alternative #3* would change the definition of high-risk service area to only include areas determined to be high-risk by the employer (i.e., an area where a workplace violence incident has occurred in the previous three years), and would not include any areas pre-determined by OSHA. Emergency rooms/emergency admissions/triage areas, psychiatric care, behavioral healthcare, substance abuse treatment, home healthcare, social assistance, and emergency medical services could still be determined to be high-risk areas, but only if they had experienced a workplace violence incident in the last three years. This change in definition would mean that employers would only need to conduct the extra assessments in (d)(1)(vi) for areas that the employer had identified as high-risk because of the occurrence of a workplace violence incident. The employer would still be required to complete all other steps in the initial assessment (paragraph (d)(1)(i)—(v)), annual hazard assessments (paragraph (d)(3)) and additional hazard assessments (paragraph (d)(4)), with the only change being to the definition a high-risk service area.

OSHA is interested in whether employers might find it equally effective to focus *only* on those areas where they are experiencing incidents of workplace violence. Accordingly, the regulatory text could differ from what OSHA has provided in this package in the following manner:

> *High-risk service areas mean settings where there is an elevated risk of workplace violence incidents. [….] An area where a workplace violence incident has occurred in the previous three years is considered to be high-risk unless the employer has a written determination demonstrating that this designation is not appropriate.*

OSHA estimates that the savings associated with this more focused approach to identification of workplace violence hazards based on employer experience, would amount to $157.3 million, or $780 per affected employer – with a percent change of annualized cost of -12.9 percent.

OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with the ability for employers to designate high-risk service areas for additional controls only based on their own individual experiences and recordkeeping within their

establishment.

Paragraph (e) Control measures

Control Measures Alternative #1: **Require only hazard assessment, workplace violence prevention plan, incident investigation, and training.**

Under this alternative, an employer would not be required to make modifications to mitigate identified hazards and risks (e.g., implementing engineering or administrative/work-practice controls). However, employers would still be required to conduct hazard assessments to serve as the basis for site-specific training for employees. This alternative would focus upon the employer development of a plan, employee participation, training, recording, and evaluation based on hazards identified in the hazard assessment. This alternative would remove the potential requirements under paragraph (e) Control measures.

OSHA views this option with significant disfavor, as it would not require a number of control measures that OSHA believes would further reduce the workplace violence hazard. However, OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with this alternative. In particular, OSHA is interested in employer experience with plan development and whether there are specific measures that must be included in a plan to ensure the plan and training provide the same protection for employees that would be provided through specified controls.

OSHA estimates that the savings associated with this approach would amount to $101.7 million, or $504 per affected employer – with a percent change of annualized cost of -8.4 percent.

Control Measures Alternative #1a: **Require that employers implement administrative/work-practice controls only -- No requirement for employers to implement environmental or engineering controls.**

Recognizing the potential for cost and the difficulty inherent in making modifications to the built environment, OSHA presents this alternative wherein the employer would not be required to implement environmental or engineering controls. This alternative would instead focus on employers implementing administrative/work-practice controls (adjusting staffing patterns, communication practices, incident response procedures, etc.), developing a workplace violence prevention plan, promoting employee participation, training, recording, and program evaluation.

OSHA estimates that the savings associated with this approach would amount to $94.0 million, or $466 per affected employer – with a percent change of annualized cost of -7.7 percent. OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with

a requirement that employers need only focus on administrative/work practice controls over engineering or environmental controls.

As with the previous alternative, OSHA views this option with significant disfavor, as it would not require engineering control measures that OSHA believes would further reduce the workplace violence hazard. However, OSHA requests feedback from SERs about any perceived benefits or drawbacks that may be associated with the ability for employers to focus solely on developing a workplace violence prevention plan, promoting employee participation, training, administrative/work-practice controls, recordkeeping, and program evaluation. OSHA is interested in whether SERs have any information suggesting that this alternative would be as effective in preventing workplace violence as including the requirements for specific controls.

Control Measures Alternative #1b: **Require that employers implement a limited set of environmental or engineering controls.**

Under this alternative, OSHA could require a clearly defined, limited set of environmental or engineering controls to address a number of specific hazards. Employers would need to conduct a hazard assessment and implement *at least one* of the controls applicable to the hazard (to the extent that any are applicable), but would not be required to implement *all* of the controls that could potentially be applicable. For example, if OSHA offers two controls for addressing the potential danger of interactions with patients or clients in a room or area not visible to others, OSHA recommend the installation of closed-circuit surveillance systems, curved mirrors located to allow others to monitor that space, or a personal panic alarm system with nearby staff to assist quickly. The employer must assess the variable in their particular space and select at least one of those controls to address the recognized hazard, but would not need to select more than one even if doing so would provide more layers of protection (e.g., the employer would not be required to install both a closed-circuit surveillance system *and* a personal panic alarm system with staff nearby).

OSHA welcomes feedback on this alternative. Are there specific environmental or engineering controls that OSHA should require in some or all covered settings? Which engineering controls are the most impactful in protecting workers? Are there any settings where OSHA should mandate the use of specific engineering controls?

Because OSHA has not determined a specific list of required environmental or engineering controls nor determined where those controls might be required, the agency has not attempted to estimate the costs associated with this potential alternative. However, OSHA expects that it would fall between the estimated costs of the draft regulatory framework ($1.22 billion) and those estimated in Control Measures Alternative #1a ($1.12 billion) (see Table 2).

Control Measures Alternative #2: **Remove requirement for all employers to develop standard operating procedures for mass shooter/mass casualty threats**

This alternative would remove the requirement for employers to develop standard operating

procedures for response to mass casualty threats such as active shooters. The draft regulatory text that OSHA has provided in this package for SER review includes a potential requirement under paragraph (e) that states:

> *(e) Control measures.*
>
> *(1) Based on the hazard assessments, the employer must establish and implement workplace violence control measures to address identified workplace violence hazards or risk factors. Each employer must:*
>
> *(ii) Establish and implement effective workplace violence incident response procedures that include, as applicable:*
>
> *(E) Standard operating procedures to respond to mass casualty threats, such as active shooters*

OSHA believes that emergency planning for mass casualty scenarios by establishments for the surrounding community are already a relatively standard practice in many healthcare establishments. This draft standard focuses on Type-II violence (violence perpetuated by patients/clients/residents and their visitors upon employees), while existing emergency planning for mass casualty scenarios may or may not be focused on Type-II violence.

OSHA estimates that the savings associated with removing this requirement would amount to $10.0 million, or $49 per affected employer – with a 0.8 percent reduction of the annualized cost.

OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with removing the requirement to develop standard operating procedures for response to mass casualty threats such as active shooters.

Control Measures Alternative #3: **Removing requirement for small business entities (only) to develop a standard operating procedure for mass casualty threats**

This alternative would remove the requirement for small entities to develop standard operating procedures for mass casualty threats such as active shooters. However, employers operating establishments that do not meet the criteria of small entity would implement standard operating procedure for mass shooter/mass casualty situations as specified in the draft regulatory text.

OSHA estimates that the savings associated with this alternative would amount to $1.0 million, or roughly $5.50 per affected small-entity employer – with a percent change of annualized cost of -0.1 percent.

OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with removing any requirement for small entities to develop standard operating procedures for response to mass casualty threats such as active shooters. OSHA also requests

feedback on what factors, if any, would make the SBA definition of "small entity" more appropriate than other types of cutoffs (the number of staff expected to be at a location at a given time, the number of staff generally without reference to the revenues of the entity, etc.).

Paragraph (f) Training

OSHA considers training to be a vital measure to reduce the risk of workplace violence in healthcare and social assistance. Many comments received in response to the RFI (OSHA 2016-0014) also emphasized the importance of training with respect to preventing workplace violence, and OSHA believes that employee training is an integral component of any workplace violence prevention plan.

OSHA's draft regulatory text requires that training be provided initially (e.g., by the effective date of this standard), upon hiring, or when existing employees are newly assigned to perform duties for which their previous training did not meet all requirements for the newly assigned duties.

- One tier of training would be designated for employees with direct patient/client/resident contact duties, which are generally higher-risk services. These would be those employees who perform support work that requires them to be in patient care areas – environmental services staff, meal delivery, etc. OSHA has estimated that this may amount to 2 hours of instruction time for employees with direct patient contact duties, as well as their immediate supervisory staff.

- Another tier of training would be designated for employees assigned to direct patient/client/resident care duties in non-high-risk services. These include employees who provide healthcare or social assistance services directly to patients or clients, and have hands-on or face-to-face contact with patients. These employees would include nurses, nursing assistants, patient care assistants, physicians, emergency medical services employees, and social workers providing social assistance services in clients' homes. OSHA has estimated that this may amount to 4 hours of instruction for employees with direct patient care duties (in non-high-risk service areas) and their supervisory staff;

- A separate and more-advanced tier of training would be designated for employees assigned to direct patient/client/resident care duties in high-risk services. This training would be for the same category of employees as described in the second tier of training, but the distinction would be that they are performing duties within services or service areas that OSHA or an employer has deemed to be high-risk. OSHA has estimated that this may amount to 8 hours of instruction for employees with direct patient care duties (in high-risk service areas) and their supervisory staff;

- A fourth and most-advanced tier of training would be required for employees who are reasonably expected to respond to incidents of workplace violence, such as security staff or incident response team members. OSHA has estimated that this may amount to 24 hours of instruction for employees specifically expected to respond to workplace violence incidents and their supervisory staff.

Training Alternative #1: **Remove annual training; retain initial training**

This alternative discusses retaining initial training requirements, but removing any requirement for employers to provide annual re-training of employees on the workplace violence prevention measures. For review, Paragraph (f) of the draft regulatory text states:

> ***(f) Training.***
>
> *(1) The employer must institute a training program for employees, who have direct patient/client/resident contact, provide direct patient/client/resident care, or are responsible for workplace violence incident response duties, and their supervisory staff. Training must be provided to these employees at the following intervals:*
>
> *(i) Initially, prior to the time of assignment, or when newly assigned to perform duties for which the training required in this subsection was not previously provided;*
>
> *(A) If an employee received workplace violence prevention training from the employer in the 12 months preceding the effective date of this standard, the employer need only provide additional training to the extent that the previous training did not meet the requirements of this standard;*
>
> *(ii) Annually thereafter; and*
>
> *(iii) Supplemental training to address specific deficiencies when:*
>
> *(A) There are changes to any procedures or controls designed to address workplace violence. This training may be limited to addressing only these changes;*
>
> *(B) Inadequacies in the employee's knowledge or work practices indicate that the employee has not retained the requisite understanding or skill; or*
>
> *(C) Any other situation that arises in which retraining is necessary to ensure employee protection from workplace violence.*

Some employers may believe that training is more efficient and cost-effective when it is provided based on their assessment of the capability of their employees, for example, through periodic skills assessments, rather than a requirement to convene routine training on a prescribed schedule. Under this alternative, employees with direct-patient/client/resident care or direct-patient/client/resident contact would only complete an initial training, and, following the initial training, would receive supplemental training only whenever there are significant changes to any workplace violence-related procedures or controls or if employees demonstrate a need for refresher training.

OSHA estimates that the savings associated with removing the requirement for annual employee retraining entirely, would amount to $755.1 million, or $3,744 per employer – with a percent change of annualized cost of -62.1 percent.

Annual training is important, particularly for engaging employees and refreshing knowledge of concepts critical to avoid injury in stressful scenarios. For example, refresher training on de-escalation skills is particularly important to trigger immediate recollection and use of those skills in the heat of the moment of a workplace violence incident when the employee will be under significant stress and decision making will be difficult. Nonetheless, OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with removal of requirements for employers to provide annual re-training of employees on the workplace violence prevention training measures outlined in paragraph (f). OSHA is particularly interested in whether SERS have experience or other information about whether incident-triggered refresher training is as effective as annual refresher training.

Training Alternative #2: **Require training for a more limited subset of employees (e.g., those with direct-patient/client/resident care and violent incident response duties only)**

Under this alternative, only employees with direct-patient/client/resident care and violent incident response duties (e.g., emergency response teams, individual responder duties) would be required to complete training. This draws the same distinction as in the Scope Alternative #1, except that employees in the *contact* group that would generally be excluded are still covered for training purposes to the extent they are part of group responsible for violent incident response. For review, the draft regulatory text defines these roles as follows:

> *Direct patient / client care means job duties that involve the delivery of healthcare services or social assistance services with hands-on or face-to-face contact with patients/clients/residents. Employees who provide direct patient/client/resident care include nurses, physicians, nursing assistants, patient care assistants, technicians, and other healthcare workers, social workers visiting client homes, as well as employees providing emergency medical services.*
>
> *Workplace violence response team means a group of employees designated to respond to violent incidents. They have advanced levels of training and do not have other assignments that would prevent them from responding immediately to an alarm to assist other staff.*
>
> *Individual Responder means an employee designated to respond to workplace violence incidents who has received an advanced level of instruction for response*. OSHA expects that a full *workplace violence incident response team* may not be necessary for some nursing homes, certain social assistance settings, group homes or similar settings, but rather that an individual responder could be sufficient to assist employees with de-escalation of workplace violence incidents.

Under this alternative, employees who have direct-patient contact (i.e., physically close to patients when performing duties), but who are not responsible for direct-patient care, would not need to receive workplace violence prevention training. For review, the draft regulatory text defines "direct patient/client/resident contact" as follows:

> *Direct patient / client contact means job duties where employees perform support work that requires them to be in patient care areas. Such work includes environmental services, engineering services, laundry services, meal delivery, information technology, and others.* For the purposes of SBREFA, security employees have been designated as patient contact employees.

OSHA estimates that the savings associated with removing the training requirement for direct patient/client/resident contact employees would amount to $19.7 million – with a percent change of annualized cost of -1.6 percent.

OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with this alternative to require training only for employees who provide direct-patient/client/resident care or designated as workplace violence incident response team members or individual responders and removing the training requirement for employees who have direct-patient/client/resident contact.

Training Alternatives #3 and #3a: **Require refresher training every 3 years (triennially) or every 2 years (biennially) instead of annually**

As explained above in Training Alternative #1, refresher training is particularly important to trigger appropriate employee responses during stressful incidents and OSHA has proposed annual refresher training for this purpose. Nevertheless, OSHA has identified the alternative of requiring employers to provide refresher training for all tiers of employees only every 3 years instead of annually**.**

OSHA estimates that the savings associated with this reduced periodicity of training (every three years instead of annually) of would amount to $510.8 million, or $2,532 per affected employer – with a percent change of annualized cost of -42.0 percent.

Alternatively, if OSHA required that employers provide refresher training for all tiers of employees every two years, OSHA estimates that the savings associated with this reduced periodicity of training (every two years instead of annually) would amount to $419.7 million, or $2,081 per affected employer – with a percent change of annualized cost of -35.0 percent. OSHA is interested to hear SERs about perceived benefits or drawbacks that may be associated with a requirement for refresher training to be provided every three years or every two years instead of every year and if SERS have experience or other information about whether triennial

refreshers, or refreshers of other frequencies, are as effective as annual refresher training.

Training Option #1: **Require advanced training for employees working in very small facilities (≤2 employees on site)**

This option would require an advanced level of instruction for all employees working in an establishment with only one or two employees on site (e.g., small behavioral health group home). These employees are likely to be less able to coordinate with other employees in order to respond to incidents of workplace violence so it may be that all employees at these establishments need advanced training in order to respond to those incidents. OSHA believes that frequently these employees may receive guidance to call 911 to deal with issues of workplace violence, however under this option, these employers would be required to provide advanced training so that employees know how to respond to workplace violence incidents. Under this alternative, 25,025 establishments (employing 48,823 employees) with two or fewer employees would get the advanced training (estimated to be 24 hours), out of 129,788 very small entities with fewer than 20 employees.

As specified previously, OSHA preliminarily estimates that employers would provide 24 hours of instruction for both employees and their supervisory staff when those employees are reasonably expected to respond to incidents of workplace violence. For employees who may be less able to coordinate with other employees in order to respond to incidents of workplace violence, this added level of training would result in an enhanced aptitude for responding to incidents in these situations.

OSHA estimates that the cost associated with training two employees under this training option would amount to $14.1 million, or $109 per affected very-small-entity employer – an increase in annualized cost of 1.2 percent.

Alternatively, if only one employee is trained under this training option, OSHA estimates that the costs would amount to $7.0 million – an increase in annualized cost of 0.6 percent.

OSHA is interested to hear from SERs about perceived benefits or drawbacks that may be associated with this additional training requirement for employees who are specifically designated to respond to incidents of workplace violence. In addition, OSHA is interested in SER feedback on a potential exception to this additional training requirement for very small facilities (≤ 2 employees on site).

Training Sensitivity Test #1: **Reduction of estimates of training length for the most advanced level of employee workplace violence prevention training**

The draft regulatory text that OSHA has provided has not prescribed any specific length of time that would be associated with the various tiers of employee training curricula. However, OSHA has provided some estimates in these supplementary materials, and assumes that employees receiving the most advanced level of training will receive 24 hours of instruction. The highest tier of training, designated for those employees expected to respond to workplace violence incidents (and their supervisors) would remain the most extensive. Under this sensitivity test, however, OSHA estimates that employees could receive adequate instruction from a curriculum of 8 hours of training, rather than 24 hours. That instruction would still be different from the training received by Tier 3 employees and would focus more on the knowledge required for individuals who are responsible for responding to workplace violence incidents.

Because the agency places great emphasis on the importance of training, OSHA believes that 8 hours may not be sufficient to ensure employees have the knowledge to respond to workplace violence incidents. Nonetheless, OSHA is interested to hear from SERs about OSHA's training estimates and the amount of training needed to ensure employees have the knowledge and skills to respond to workplace violence incidents.

OSHA estimates that the savings associated with these reduced training hour estimates would amount to $19.8 million, or $98 per employer – with a percent change of annualized cost of -1.6 percent.

Paragraph (g) Violent incident investigation and recordkeeping

Violent Incident Investigation and Recordkeeping Alternative #1: **Require post-incident investigations only for workplace violence incidents involving physical assault**

This alternative would require a post-incident investigation only if the workplace violence incident involved a physical assault (i.e., not if the incident was only a *threat* of physical assault). Under the draft regulatory text, all workplace violence incidents must be investigated. According to the definition of workplace violence incident provided in this draft standard:

> *Workplace violence incident* means any violent act (including physical assault ***and threat of physical assault***) directed toward persons at work or on duty by patients or their visitors. ***It may or may not result in injury***.

OSHA understands that given the nature of some healthcare and social assistance services covered within several sectors in the scope of this draft standard, there may be patients or clients who issue verbal or present physical threats regularly due to emergent health conditions and/or mental health crises, and it may be challenging and time-consuming for employers to investigate every threat. OSHA also acknowledges that the most pressing type of incident to investigate are those that involve physical assault. By limiting investigations to incidents of physical assault, employers may be able to focus on the highest-risk incidents.

To estimate the cost savings for this alternative, OSHA removed cases of non-lost-workday (non-recordable) incidents (see Table 3) from the body of events that would trigger an investigation. OSHA estimates that the savings associated with this violent incident investigation alternative would amount to $13.7 million, or $68 per affected employer – with a percent change of annualized cost of -1.1 percent. The result is an overestimate of the savings because some of those removed cases involved actual physical injury, not just threats, even if that injury was not significant enough to warrant a lost workday. OSHA is not aware, however, of an alternative method that would provide more accurate results.

OSHA estimates that, out of 619,000 incidents investigated for all reasons, this regulatory alternative results in a 38 percent reduction in investigations, or 232,000 fewer investigations. Under this alternative, employers would investigate all workplace violence incidents except for those exclusively involving threats.

OSHA is interested to hear from SERs about perceived benefits or drawbacks that may be associated with requiring violent incident investigations to be conducted only for workplace violence incidents associated with a physical assault.

OSHA also invites comment from SERs on an expansion to this Recordkeeping Alternative #1 that would require a post-incident investigation only if the workplace violence incident involved care beyond first aid. For example, if the employee does not require any care (e.g., they experienced minor scratches/bruising), no investigation would need to be conducted by the employer.

OSHA views this expansion to Alternative #1 with disfavor, as many workplace violence incidents result in injuries that may not rise beyond the need for first-aid yet may still inflict emotional and psychological injury. Such incidents may be the result of an incident that rose above the threshold of a near-miss, however more significant injury was only narrowly averted and could have been much worse. The investigation of these seemingly less severe incidents may help to prevent future injuries and fatalities. Nonetheless, OSHA is interested to hear from SERs about perceived benefits or drawbacks that may be associated with only requiring violent incident investigations for workplace violence incidents that result in injuries that exceed those of first-aid.

Provision of Post-Incident Medical Treatment and Mental Health Evaluations Option #1: **Employers would be required to offer and provide post-incident medical treatment and mental health evaluations for employees who have experienced workplace violence incidents that result in injuries requiring treatment beyond first aid.**

Under this option, employers would provide post-incident medical and mental health evaluations

and treatment for the affected employee for a period not to exceed one year, at no cost to the employee. This option would require post-incident medical treatment and mental health evaluations only if the workplace violence incident involved care beyond first aid (i.e., minor cuts/scratches). Of 619,000 violent incidents in the workplace, OSHA estimates that eight percent, or 49,520 violent incidents, require treatment beyond first aid. If the employee does not require any care beyond first aid, the employer need not provide medical treatment and mental health evaluations.

Time associated with an employee receiving post-incident medical and mental health evaluations/treatment, and reasonable travel time (as appropriate) shall be considered compensable time. Under this option, OSHA has assumed one hour of evaluation per week for one year, with $5 of travel time per session. For WPV recordable, lost-workday incidents, the costs of post-incident medical treatment and/or mental health evaluations will total $108.7 million ($539 per affected employer), raising total costs for the WPV regulatory framework to $1.32 billion. For WPV recordable non-lost-workday incidents, the costs of post-incident medical treatment and/or mental health evaluations will total $231.6 million ($1,148 per affected employer), raising total costs for the WPV regulatory framework to $1.45 billion. Estimation of total cost is based on average annual per-employee cost of $2,200 applied to estimated OSHA recordable incidents. This estimate is also based on an assumption that all affected employees would use one full year of weekly counseling. OSHA believes this may be a significant over-estimate of affected employees who may wish to engage in such post-incident services, or may wish to engage in post-incident services for a full year. Based on a review of recent employee assistance program literature, OSHA observes that employee utilization of employer assistance programs ranged from 2.1 percent to 8 percent from 2015 to 2018 with an increased demand for services treating anxiety or stress during the COVID-19 pandemic.[48] OSHA is interested to hear SERs input on this option that would require employers to offer post-incident medical and psychological evaluations and treatment, as well as the experiences of SERs who may already offer such services, and how frequently affected employees currently make use of such services.

Paragraph (j) Effective Date of the Standard

OSHA has presented multiple over-arching regulatory components in this informational package. These include elements of paragraphs:

(c) Workplace Violence Prevention Program (WVPP);
(d) Workplace violence hazard assessment;
(e) Control Measures;
(f) Training;

[48] Brooks and Ling (2020) found that utilization of services treating anxiety and stress increased during the COVID-19 pandemic, but that overall utilization of these services declined between the first and second quarter of 2020. See also SHRM, 2019, and Chestnut Global Partners, 2016.

(g) Violent Incident Investigation and Recordkeeping;
(h) Retention of Records; and
(i) Anti-Retaliation.

Paragraph (j) Effective Date of the draft standard states that all provisions would become effective 60 days after publication, and that all employers would need to comply with all provisions within six months after publication. OSHA estimates that many employers would not have significant difficulty coming into compliance in six months.

OSHA welcomes information from SERs regarding which, if any, of the draft provisions would be difficult for small entities to comply with within six months, and why it would be difficult. For those provisions that SERs believe warrant a longer period of time for compliance, OSHA welcomes input on whether nine or twelve months is needed to comply, and the reasons for additional time.

General Alternative: OSHA opts to take no action on this draft standard on Prevention of Workplace Violence in Healthcare and Social Assistance, and continues to address workplace violence hazards in healthcare and social assistance solely through use of the General Duty Clause.

OSHA could decide not to promulgate a new rule addressing workplace violence in the healthcare and social assistance sector. Instead, OSHA could continue to protect employees from this hazard through enforcement of the OSH Act's General Duty Clause (29 U.S.C. 654(a)(1)). The General Duty Clause requires "[e]ach employer" to "furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees" (*id*.).

As described in more depth in Section III, Reasons Why Action is Being Considered by OSHA, OSHA does not believe this approach would adequately protect workers in the healthcare and social assistance sectors from the risks of workplace violence. The General Duty Clause is typically more difficult to enforce than a standard and it is a less comprehensive approach to addressing the workplace violence hazard because it does not specify the actions employers must take to reduce the hazard. In that sense, a workplace violence standard also provides more notice to employers about the steps that must be taken to address the hazard.

Furthermore, OSHA received two workplace violence rulemaking petitions in 2016, one from a coalition of labor organizations (American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), American Federation of Government Employees (AFGE), AFSCME, SEIU, Teamsters and United Steelworkers, and American Federation of Teachers (AFT)), and the other from the National Nurses United (NNU). OSHA granted the rulemaking petitions on January 10, 2017, stating that "workplace violence is a serious occupational hazard that presents

a significant risk for healthcare and social assistance workers" and that a workplace violence standard "is necessary." Discontinuation of the rulemaking process would likely subject OSHA to additional litigation. Nonetheless, OSHA would be interested to hear from SERs about perceived benefits or drawbacks that may be associated with an option where OSHA takes no rulemaking action with regard to prevention of workplace violence in healthcare in social assistance, and simply continues to address workplace violence hazards through the General Duty Clause.

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