# 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**.

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# 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.

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***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?

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***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**

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- 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?

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***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?

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***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?

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***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.