Section I. Introduction

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

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

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

Background

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

Regulatory Framework

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

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

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

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

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

SBREFA process

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

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

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

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

(b)(1) a description of the reasons why action by the agency is being considered;
(b)(2) a succinct statement of the objectives of, and legal basis for, the proposed rule;
(b)(3) a description of and, where feasible, an estimate of the number of small entities to which the proposed rule will apply;
(b)(4) a description of the proposed reporting, recordkeeping, and other compliance requirements of the proposed rule, including an estimate of the classes of small entities that will be subject to the requirements and the type of professional skills necessary for preparation of the report or record;
(b)(5) an identification, to the extent practicable, of all relevant federal rules that may duplicate, overlap, or conflict with the proposed rule; and

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

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

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

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

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

Section II (p. 6) describes the legal requirements OSHA must meet if it engages in rulemaking;
Section III (p. 8) discusses the reasons why action is being considered by OSHA;
Section IV (p. 32) summarizes and explains the important provisions of OSHA’s regulatory framework;
Section V (p. 88) identifies the types of small entities that would likely be affected by a rule as outlined in the regulatory framework and provides information on the potential impacts of a rule as outlined in the regulatory framework;
Section VI (p. 206) provides a review of any potentially conflicting and duplicative regulations;
Section VII (p. 213) presents, for consideration by the SERs and the Panel, alternatives and/or options to the scope of, and provisions in, the regulatory framework.
Some of the most valuable contributions SERs make in the SBAR Panel process are their comments on the alternatives and/or options presented and their suggestions for other possible alternatives.
Section II. Legal Requirements OSHA Must Meet if It Engages in Rulemaking


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

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

Courts recognize that a determination of what constitutes significant risk will be “based largely on policy considerations.” Benzene, 448 at 655 n.62. OSHA “is not required to support its finding that a significant risk exists with anything approaching scientific certainty [,]” and “is free to use conservative assumptions” and “risk [] error on the side of overprotection rather than under protection.” Id. at 656; see also Public Citizen Health Research Group v. Tyson, 796 F.2d 1479, 1486 (D.C. Cir. 1986) (“Ethylene Oxide”). It is sufficient for OSHA to make a general finding of significant risk; the agency is not required to assess relative risk or disaggregate its significant risk analyses by hazard, workplace, or industry. See, e.g., UAW v. OSHA, 37 F.3d
665, 670 (D.C. Cir. 1994) ("Lockout/Tagout II") (upholding OSHA’s decision not to conduct individual significant risk analyses for various affected industries); American Dental Ass’n, 984 F.2d at 827 (OSHA is not required to evaluate risk “workplace by workplace”); Associated Builders & Contractors, Inc. v. OSHA, 862 F.2d 63, 68 (3d Cir. 1988) (noting that “the significant risk requirement must of necessity be satisfied by a general finding concerning all potentially covered industries’); Ethylene Oxide, 796 F.2d at 1502 n. 16 (rejecting the argument that the Secretary must find that each and every aspect of its standard eliminates a significant risk).

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

Overview

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

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

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

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

3 The Bureau of Labor Statistics (BLS) released its Survey of Occupational Injuries and Illnesses (SOII) for 2020 in mid-November 2021. BLS publication schedules indicate that newer data will not be available in the near future. However, because 2020 was such an atypical year for the healthcare industry due to the COVID-19 pandemic, and because there was insufficient time for OSHA to conduct a thorough analysis of the recently-released 2020 data in advance of this SBREFA Panel, this section primarily presents injury data associated with “intentional injury by other person” from 2019. In general, the reported rates from BLS attributed to intentional workplace violence in the SOII increased in 2020, and OSHA has footnoted some of the 2020 data while discussing 2019 data, for SERs to reference. OSHA also presents some injury data that falls within BLS’s classification “injury by person-unintentional or intent unknown.” Within that category, data categorized as “restraining-subduing-unintentional” falls within OSHA’s definition of workplace violence for this proposed standard because it includes injuries while restraining or subduing patients or clients. OSHA did not include, however, other data in the “injury by person-unintentional or intent unknown” category, because some of these injuries fall outside OSHA’s definition of workplace violence. Note that this data encompasses workplace violence only in BLS-designated “private industry”; it does not encompass workplace violence incidents in other facilities such as government-operated facilities. The rates of violent incidents is generally higher in those other facilities, but many of those would not be subject to OSHA standards.
2019 show that the average rate of workplace violence incidents for all industries is estimated at a lost-workday incidence rate of 2.0 per 10,000 employees per year.\(^4\)

By comparison, healthcare and social assistance workers experienced a rate of violence nearly six times that, with workplace-violence-related injuries at an estimated lost-workday incidence rate of 11.7 per 10,000 full-time workers per year (9.7 intentional injury by another person and 2.0 unintentional injury while restraining or subduing)\(^5\)-- with a total of 16,450\(^6\) nonfatal injuries in 2019 alone. For certain segments of the healthcare and social assistance industry, the injury rate is even higher, such as in psychiatric and substance abuse hospitals, which had 146.5 injuries per 10,000\(^7\) full-time workers per year (107.5 intentional injury by another person and 39.0 unintentional injury while restraining or subduing), and residential intellectual and developmental disability, mental health, and substance abuse facilities, which had 55.6 injuries per 10,000\(^8\) full-time workers per year (44.4 intentional injury by another person and 11.2 unintentional injury while restraining or subduing) (BLS, 2019, R-4, R-8, and Special Run for Intentional vs. Unintentional 2019-2020).

Additional data pertaining to nonfatal workplace violence incidents severe enough to cause days away from work are presented in Figure-1. Note that these injuries can be significant and often require many days away from work -- ranging from 1 to 180 days. The average of the median number of days away from work for each injury is 14 days. (BLS Special Run Data - Number, median days away from work and relative standard errors of occupational injuries and illnesses involving days away from work 3 in health care and social assistance from violence by industry, occupation, and source for All United States, 2019)

Figure-1 lists the number and rate of workplace violence injuries for each sector in OSHA’s contemplated scope. Not listed in Figure-1 (but included in OSHA’s draft scope) are freestanding emergency centers and firefighters cross-trained in EMS for which OSHA does not have equivalent data at this time.

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\(^4\) BLS data for 2020 “all industries” is a rate of 2.1 per 10,000 full-time workers per year.
\(^5\) BLS data for 2020 “healthcare and social assistance” is a rate of 17.3 injuries per 10,000 full-time workers per year (10.3 intentional injury by another person and 0.7 unintentional injury while restraining or subduing).
\(^6\) BLS data for 2020 “healthcare and social assistance” is 15,210 non-fatal injuries.
\(^7\) BLS data for 2020 “psychiatric hospitals and substance abuse hospitals” is a rate of 161.6 injuries per 10,000 full-time workers per year (114.2 intentional injury by another person and 47.4 unintentional injury while restraining or subduing).
\(^8\) BLS data for 2020 “residential mental health care facilities” is a rate of 50.7 injuries per 10,000 full-time workers per year (41.3 intentional injury by another person and 9.4 unintentional injury while restraining or subduing).
**Figure-1**

*Number and Rate of WPV Injuries for Industry Sectors in the Contemplated Scope, 2019.*

<table>
<thead>
<tr>
<th>Sector</th>
<th>NAICS</th>
<th>Industry</th>
<th>Injuries</th>
<th>Rate per 10,000 FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>General hospitals, incl. emergency departments</td>
<td>622000</td>
<td>Hospitals</td>
<td>7,160</td>
<td>17.8</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>622200</td>
<td>Psychiatric and substance abuse hospitals</td>
<td>1600</td>
<td>152</td>
</tr>
<tr>
<td></td>
<td>623200</td>
<td>Residential behavioral health facilities</td>
<td>3120</td>
<td>58.2</td>
</tr>
<tr>
<td></td>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>130</td>
<td>26.6</td>
</tr>
<tr>
<td>Residential care facilities</td>
<td>623100</td>
<td>Nursing care facilities</td>
<td>780</td>
<td>19.1</td>
</tr>
<tr>
<td></td>
<td>623300</td>
<td>Continuing care retirement communities and assisted living facilities for the elderly</td>
<td>3280</td>
<td>14.4</td>
</tr>
<tr>
<td>Home healthcare</td>
<td>621600</td>
<td>Home healthcare</td>
<td>620</td>
<td>6.1</td>
</tr>
<tr>
<td>Emergency medical services</td>
<td>621910</td>
<td>Ambulance Services</td>
<td>260</td>
<td>18.6</td>
</tr>
<tr>
<td>Social assistance services</td>
<td>624100</td>
<td>Individual and Family Services</td>
<td>300</td>
<td>20.5</td>
</tr>
<tr>
<td></td>
<td>624200</td>
<td>Community Food and Housing, and Emergency and Other Relief Services</td>
<td>140</td>
<td>8.9</td>
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<tr>
<td></td>
<td>624300</td>
<td>Vocational Rehabilitation Services</td>
<td>530</td>
<td>21.8</td>
</tr>
</tbody>
</table>

Source: BLS, Tables R4, R8 (2019)

*Survey Results Show the Prevalence of Workplace Violence*

The literature on workplace violence includes a number of surveys of healthcare and social assistance workers, which are useful for understanding the prevalence of workplace violence. Particularly because of the limitations associated with underreporting discussed below, surveys of healthcare and social assistance workers are especially useful in accurately characterizing the extent of the workplace violence risk. In the social assistance sector, for example, one survey of 175 licensed social workers and 98 agency directors found that 25 percent of social workers had experienced assault by a client, nearly 50 percent had witnessed violence in a workplace, and more than 75 percent were fearful of violence occurring. (Rey, L. 1996). A longitudinal study of 1,501 child protective services workers found that they experienced high levels of what the authors termed “nonphysical violence” (yelling, shouting, property damage) (75 percent), threats (37 percent), and physical violence (2.3 percent) the first 6 months on the job (Radey, 2021).

Similarly, in the healthcare industry, another survey of 762 nurses in a variety of inpatient settings revealed that in the prior year approximately 54 percent experienced verbal violence from patients, approximately 30 percent experienced physical violence from patients, and 76 percent of the nurses experienced at least one instance of violence involving a patient or a patient’s visitor (Speroni, K.G., et. al. 2014).
A study of approximately 2,900 nursing assistants working in long-term care facilities found that 34 percent had sustained a physical injury from an assault by a resident in the prior year (Tak, S.W., et. al 2010). Reports from home healthcare workers also indicate high rates of workplace violence. In one study, 30.2 percent of home healthcare workers surveyed had experienced workplace violence at some point during their careers, and 22.3 percent had experienced it during the prior 12 months (Byon, 2020).

Another study analyzed a series of individual surveys from 1995 to 2018 that included clinicians (providing direct patient care) and non-clinicians of psychiatric inpatient units. Each individual survey encompassed the workers’ prior year of experience in small clinics, mental health services, and large psychiatric hospitals that serve elderly, adults, and children. Depending on the surveyed population, a range of 25 to 85 percent of workers surveyed from the various sites reported episodes of physical aggression during the prior year (Odes, et al. 2021).

According to National Nurses United, which conducted a survey of nurses’ experiences with workplace violence from 2017-2019, physical injuries resulting from WPV in the Health Care and Social Assistance sector range from minor bruising and abrasions to more serious injuries including broken bones, internal tissue damage, and even death. (NNU, 2021) Among the 402 nurses who took the survey, only 16.7 percent reported had not experienced workplace violence. In the report titled *Injury to None*, NNU cited continued and escalating experiences with type II violence (e.g., violent acts committed by patients or their visitors) in various areas of the healthcare system such as emergency rooms, outpatient clinics, pediatrics, and labor and delivery rooms (NNU, 2021).

**OSHA Stakeholder Meeting on Workplace Violence**

OSHA has also heard first-hand accounts of the extent and severity of the workplace violence hazard in the healthcare and social assistance industry. At a Workplace Violence Stakeholder Meeting convened at the Department of Labor in January 2017, OSHA heard testimony from workers detailing violent assaults that they or their colleagues had endured from agitated patients.

One home healthcare worker described a colleague who had been killed by her client’s son, who was upset that the worker was in the home. (Ex. 0097, pg. 253) Another worker, a nurse for

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9 In this document, OSHA references documents in Docket No. OSHA-2016-0014, the docket for Prevention of Workplace Violence in Healthcare and Social Assistance. This docket includes documents associated with and comments received in response to the December 7, 2016 Request for Information. OSHA has placed all references in this document in the public docket at and is available to help SERs obtain any references they would like to see. All non-copyrighted references will be available online at regulations.gov in the docket for this potential rulemaking.
over 45 years, both in psychiatric and emergency settings, described how she has been “bitten, kicked, punched, pushed, pinched, shoved, scratched and spat upon.” She said that she had her life, the life of her unborn child and other family members threatened, which required security to escort her to her car. This worker also described an instance when her emergency nursing colleague was a victim of a surprise, unprovoked patient attack where she was “strangled and swung around like a little rag doll, all the while being threatened with death” by the patient. She went on to describe attacks on other emergency nursing colleagues of hers, such as “one [who] had been kicked in the head over ten times, was severely concussed, and had lasting injuries and is no longer working in nursing. Another had been attacked by a patient on PCP. [The colleague] intervened with an attack on another patient and was hit with a IV pole.” (Ex. 0097, pp. 104–105)

Many of these workplace violence incidents result in severe and permanent injuries. A registered nurse at a 22-bed psychiatric unit in a major acute care hospital in Connecticut described how in the past seven years, she had suffered two very serious injuries that each required surgery.

On October 11th, 2009, I went to work as usual at 7:00 a.m., not knowing that that day my life would suddenly change. That afternoon, as I was nearing the end of my shift, I approached a 25-year old male patient to hand him his medication and a glass of water.

In the next moment, I went from being a professional nurse doing my job to a helpless victim of workplace violence. Without warning, the patient suddenly became viciously violent. He punched me in my jaw with his full strength, hurling me backward onto the floor. The impact of my body crashing down shattered my left leg at the hip. I lay on my back in excruciating pain. All of the bones and soft tissues in my hip were broken and torn. Only my skin held my now lifeless leg onto my body.

Initially, I could not comprehend what had happened. The pain was the worse I had ever experienced. I immediately felt helpless and uncertain about whether I would recover from such a catastrophic injury. My recovery was painful and difficult. It began with a complete reconstruction of my femur and hip. An orthopedic surgeon successfully put my leg back together, rebuilding my hip with supporting rods so that I would eventually walk again.

After surgery, I remained in the hospital for five days, followed by another three weeks

To find a reference from this document, go to http://www.regulations.gov, the Federal eRulemaking Portal. From there, references are found by looking up the document ID number. The docket number for this rulemaking, and therefore the beginning of each document ID number, is OSHA-2016-0014. References to documents in the docket are given as “Ex.” followed by the document number and, in the case of the longer documents, such as the transcript of the public meeting, the page number. For example, Ex. 1, the Request for Information, is Document ID Number OSHA-2016-0014-0001. Likewise, Ex. 0097, the transcript from the January 7, 2017 Workplace Violence Stakeholder Meeting, is Document ID Number OSHA-2016-0014-0097.
of intensive rehabilitation in an inpatient rehabilitation facility. After an additional six months of outpatient physical therapy, I was cleared to return to work. I did so and continued to work on the same psych unit to this day.

My other injury occurred just last May 7th. The injury happened as I was seated at a desk in the hallway, entering patient progress notes into a computer. A 50-year old female patient with a known history of violence, who was supposed to be restricted to her room, walked down the hall towards me. As she reached my vicinity, she grabbed my left upper arm with her fist and with her left hand she proceeded to make a punch to my face. A security guard assigned to the unit was nearby and pulled her away before she slugged me. However, the twisting motion of my body resulted in two torn meniscii in my right knee. Subsequently, medical evaluation determined that I would not recover without surgical intervention.

After the surgery and physical therapy, I recovered and was cleared to return to work. Again, I was out of work for six months. Both of these injuries were seriously traumatic, physically, emotionally and psychologically. Both workplace violence events necessitated trauma counseling. The second event required extensive counseling for PTSD.

However, at times even after counseling I still feel traumatized and vulnerable, feelings that never completely go away. (Ex. 0097, pp. 66-72)

OSHA heard testimony from several dozen nurses within various professional settings, emergency medical technicians, home healthcare workers, psychiatric technicians, physicians, and their representatives describing similar violence that they had either experienced or witnessed on the job. (Ex. 0097)

**Media Reports on Workplace Violence**

Severe WPV incidents have also received attention in the media. One incident involved a psychiatric technician who was strangled with his own lanyard by a patient in August 2012 (Romney, 2012). In another incident in May 2017, an incarcerated individual was receiving care at an Illinois hospital and was left unshackled by the guard because of his requests to use the bathroom. The inmate took the gun of the guard and escaped, and the guard ran and hid without alerting the hospital that the inmate had escaped and was armed. The inmate took one nurse hostage and severely physically abused her, and when another nurse entered the room, he took her hostage and left for another secluded area, where he beat and raped her at gunpoint (NBC, 2017).

In November 2020, a Seattle social assistance case manager was stabbed 12 times and killed by a disgruntled client who thought he was going to be evicted. Surveillance video showed him
entering her office with a large knife. The case manager’s screams alerted a co-worker, who recognized the client and witnessed him stabbing the case manager. The client then chased the co-worker, and after the co-worker locked herself in her office, the client continued to attack the case manager, leaving the knife in her back. The client attacked another worker as he left the building and was later arrested (Green, 2020).

In October 2021, a pregnant nurse in a Florida hospital behavioral unit was administering medication to one patient when another patient entered the room, attacked her and attempted to kick her, shoving her against a wall. The attack killed her unborn child (Mark, 2021).

More recently, in January 2022, an Illinois Department of Child and Family Services (DCFS) investigator was performing a home visit alone in response to the welfare of six children. The investigator was stabbed to death, and the police took a person who lived at the house into custody. (Spearie, 2022)

_Underreporting_

While all of this data and these personal accounts indicate that workplace violence is significantly worse for workers in healthcare and social assistance than for workers in other industries, that data may still obscure the significance of the risks due to underreporting. Since BLS and other agencies rely on employers to report injury and illness data, the injury rates associated with workplace violence likely underestimate the risk faced by healthcare and social assistance workers. OSHA has long recognized that underreporting of all types of injuries (regardless of cause) exists in healthcare and social services, and underreporting obscures and understates the true extent of problems that may exist. In 2013, OSHA completed an analysis of its National Emphasis Program on Injury and Illness Recordkeeping. Through reconstruction of employee records by inspectors, OSHA found that within nursing care facilities in calendar years 2007 and 2008, over 20 percent of employee injury cases that involved days away from work were either not recorded or incorrectly recorded by the employer (OSHA, 2013).

The U.S. Government Accountability Office (GAO) has also identified problems with underreporting of workplace violence incidents in the healthcare industry. In its 2016 report “Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence,” it analyzed four national datasets (the Survey of Occupational Injuries and Illnesses (SOII) and Census of Fatal Occupational Injuries (CFOI) from BLS, the National Electronic Injury Surveillance System (NEISS-Work) from Centers for Disease Control (CDC)/National Institute for Occupational Safety and Health (NIOSH), and the National Crime Victimization Survey (NCVS) from the Bureau of Justice Statistics) to evaluate the rate of workplace violence committed against healthcare workers.
The GAO analysis found that workers in healthcare facilities experience “substantially higher estimated rates of nonfatal injury due to workplace violence compared to workers overall.” GAO concluded that the full extent of the problem with workplace violence in healthcare and social assistance could not be known for three main reasons:

1) Differences in the criteria each data set used to record workplace violence cases. The SOII and NEISS-Work datasets do not include workplace violence that does not result in severe injuries that require days off from work or an emergency room visit. The NCVS data does not include cases that are not considered crimes.

2) Employees underreporting workplace violence incidents. GAO also conducted a systematic review of published studies from January 2004 to June 2015 and several studies indicated that workplace violence incidents are often underreported. The studies GAO reviewed estimated that healthcare workers formally report between just seven to 42 percent of workplace violence incidents, indicating that a substantial proportion of workplace violence incidents are not reported.

3) Employer inaccuracies in reporting workplace violence incidents. GAO cited OSHA and BLS research from 2012 stemming from a review of the OSHA National Emphasis Program on Recordkeeping and Other Department of Labor Activities Related to Accuracy of Employer Reporting of Injury and Illness Data (for years 2007 and 2008) that indicated that employers do not always record, or accurately record, workplace injuries in general. For example, an employer may record a case but not correctly categorize it as a case that involved days away from work, restricted work activity, or job transfer. Specifically, in this instance, OSHA found that within nursing care facilities over 20 percent of employee injury cases that involved days away from work were either not recorded or incorrectly recorded by the employer (GAO, 2016 & OSHA, 2012).

The literature on workplace violence has often identified underreporting as an issue, as well. For example, Arnetz, et. al. (2015) looked at underreporting of workplace violence events in an American hospital system by surveying 2,010 healthcare workers, 22 percent of whom responded. The study found that 88 percent of those workers participating in the survey responded they had experienced an incident within the past year, but only 12 percent indicated that they had formally reported the incident to their employers through the hospital’s mandatory electronic reporting system. Employees who were injured or had lost time from work were more likely to formally report a workplace violence incident.

Likewise, Snyder, et. al., (2007), found a large proportion of workplace violence incidents go unreported. The study investigated aggressive incidents from patients against certified nursing assistants (CNAs) in a sample of 76 CNAs across six geriatric care facilities. The results indicate that these CNAs experienced a median of 26 aggressive incidents over the course of the two-
Another study described 827 violent events among 213 emergency department health care workers at six hospitals over a nine-month period. Eligible study participants provided direct patient care and worked 20 hours per week or more. Study participants included physicians, nurses, patient care assistants, paramedics, social workers, physician assistants and nurse practitioners. The study reports an estimated average of 5.528 violent events per year per person (4.017 physical threats, 1.51 physical assaults per person over one year). Workers filed a safety report 42 percent of the time and filed a police report 5 percent of the time. This suggests underreporting of safety reports of 58 percent (Kowalenko, 2013).

In a survey of 5,385 workers from two large hospital systems, one in Texas and the other in North Carolina, 39 percent indicated that they experienced at least one violent event (physical assault, physical threat, or verbal abuse, by a patient or visitor) in the prior year. Among these workers, 75 percent indicated they reported the event in some way (e.g., co-worker, manager, first report of injury (FRI) system), but only 9 percent indicated they reported into a formal occupational injury/safety reporting system. Workers were unclear about when and how to report and decided whether to report based on the event circumstances. Workers were more likely to report if they were physically assaulted, or physically threatened, if they incurred an injury, or when they were worried about personal safety at work. Also, 35.3 percent of the workers did not report because they felt that the patient or visitor had no intent to harm, subjectively differentiating the intent based on the patient’s medical condition (Pompeii, et. al. 2016).

In a meta-analysis of 21 studies between January 1, 2005 and March 20, 2019, researchers found the prevalence of physical type II violence for professional home health workers (HHWs) in one year was higher than for paraprofessionals, although this could be because paraprofessionals underreport more often. Paraprofessionals normally have less job security, may not have as much familiarity working in a private home or establishing safe boundaries and may experience a fear of retaliation if they report. (Byon, et. al., 2020)

In a survey study within a sample of 242 emergency staff workers, 37 percent reported experiencing physical assault within the past six months. Men in the study had a higher perceived sense of safety than women. Although the security staff in the sample were more likely to report WPV formally, possibly because they were familiar with the process, 69 percent of the staff never formally reported physical violence due to barriers such as the belief that violence is
“part of the job,” difficulty in defining reportable workplace violence, navigating the complexities of the reporting process, no time at work to report incidents, fear of retribution, and perceived lack of manager, supervisor or institutional support. (Mcguire, et al. 2021).

Additionally, when OSHA issued its request for information on workplace violence in 2016, several commenters who responded included comments about underreporting of workplace violence. A commenter from Drexel University School of Public Health with expertise in Emergency Medical Services (EMS) shared an analysis of underreporting from EMS responders:

Underreporting of the issue is a great cause for concern. One of the limitations that we noted from the literature is the perception that assaults are an inherent to the profession and reporting violent incidents implies an inability to perform their job competently (Corbett, 1998). Attitudes such as these have been suggested as a cause for significant underreporting of violence by EMS responders (Pozzi, 1998). A survey of 1,500 medical providers in New Mexico found that 56% of EMS respondents stated that violence is “just a part of the job” (Feiner, 1995). And although a large percentage believe violence is a part of the job, 40% believed that if no one was injured during the incident that there was no need to report (Feiner, 1995). Other studies show higher frequencies, up to 71%, believing that violence is a part of their job (Pozzi, 1998). In a survey of Canadian paramedics, 62% of participants stated that no actions were taken by most paramedics in response to the violent events (Bigham et al., 2014). In that same study, 61% of participants did not report the violence to a superior or authority and 81% did not formally document the occurrence in the patient care report (Bigham et al., 2014). Similarly, one study found that only 31% of all violent encounters were properly mentioned in the paramedic narrative (Mock, et al., 1998). (Ex. 0194)

National Nurses United (NNU) commented that:

It is important for OSHA to note that many sources of data on workplace violence underreport its prevalence. This is, in part, due to the mistaken understanding in healthcare that workplace violence is part of the job. Oftentimes, hospital supervisors and managers perpetuate this dangerous view of workplace violence, reifying the idea that reporting incidents is futile. In focus group-style discussions, NNU members have reported that supervisors and managers respond to reports of workplace violence with comments or actions that communicate to workers that it is just “part of the job.” Also reflected in NNU members’ experience with workplace violence, it is common for supervisors and managers to discourage employees from making reports of violence from patients. RNs also describe in discussions on workplace violence that they are hesitant to report violence from patients with dementia or other conditions that cause disorientation and combativeness, because they fear their patients, for whom they serve as
advocates, will be criminally punished, otherwise blamed, or denied care as a result. These reasons for underreporting underline the importance of clear communication procedures to effective workplace violence prevention plans and of protections, like non-retaliation policies, for reporting incidents and concerns about risks of violence. All incidents of violence must be reported for the prevention plan to be fully effective, but employees need training on why reporting is important and how to report without fear of reprisal for themselves or their patients. (Ex. 0235)

OSHA is troubled by these data and believes that a standard on prevention of workplace violence in healthcare and social assistance will both protect workers at risk as well as bring clarity to the extent of the hazard in this industry.

**Enforcement of the General Duty Clause and Current Non-Mandatory Guidance is Inadequate to Substantially Reduce the Risk of Workplace Violence in the Healthcare and Social Assistance Sectors**

OSHA currently enforces Section 5(a)(1) of the OSH Act, 29 U.S.C. § 654(a)(1), against employers that expose their workers to the recognized workplace violence hazard. Also known as the General Duty Clause, Section 5(a)(1) requires that “Each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.”

Yet OSHA’s existing enforcement mechanisms are insufficient because section 5(a)(1) does not specifically prescribe how employers are to eliminate or reduce their employees’ exposure to workplace violence, so even in cases where OSHA prevails, the employer need not necessarily implement the specific abatement measure(s) OSHA established would materially reduce the hazard – they can choose alternatives and OSHA must then prove that the hazard remains even after implementation of those alternatives. In addition, when relying on § 5(a)(1), OSHA must demonstrate in each case that workplace violence is a hazard and that specific controls will address that hazard, whereas an OSHA standard that requires or prohibits specific conditions or practices establishes the existence of a hazard comprehensively and establishes the effectiveness and feasibility of controls to address the hazard. In this expansive and growing industry, reliance on § 5(a)(1) is therefore a relatively inefficient means of ensuring the safety of more than 20 million employees from the recognized hazard of workplace violence.

Based on a November 2021 OSHA review of enforcement activity conducted between 2010-2020, OSHA had conducted 779 inspections related to workplace violence, resulting in 63 General Duty Clause citations and 448 Hazard Alert Letters (HALs). The majority of those inspections (530 inspections, 51 citations, 314 HALs) occurred in healthcare or social service facilities. (OSHA, 2021)
OSHA first issued guidance on reducing workplace violence in healthcare and social assistance more than twenty years ago. OSHA published the first guidance documents on this topic in 1996 titled *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers* and launched a Nursing Home Health and Safety Initiative. NIOSH also began to focus on this issue in 1996, when it published a report titled *Violence in the Workplace* which indicated that workplace violence was high in the healthcare and social assistance sectors. (NIOSH, 1996).

Below OSHA summarizes some its additional guidance, enforcement, and reports related to workplace violence prevention in healthcare and social assistance since 1996.

In 2004, OSHA revised its *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*. This revision created an outline of a workplace violence prevention program for healthcare and social services sectors, including the five main components:

1. **Management Commitment and Employee Involvement**: Management should equally commit to the safety of workers and patients/clients/residents and employees should be involved and provide feedback on the design, implementation, and evaluation of the program.
2. **Worksite Analysis**: Employers should analyze and track records of workplace violence and analyze workplace security.
3. **Hazard Prevention and Control**: Employers should implement engineering controls, workplace adaptations, and administrative and work practice controls to minimize risk.
4. **Safety and Health Training**: Training should include the workplace violence prevention policy, Risk factors that cause or contribute to assaults, and early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults.
5. **Recordkeeping and Program Evaluation**: Employers should record incidents of abuse, verbal attacks or aggressive behavior that may be threatening and measure improvement based on lowering the frequency and severity of workplace violence.

In 2011, OSHA issued Directive CPL 02-01-052 Enforcement Procedures and Scheduling for Occupational Exposure to Workplace Violence. This Directive provided instruction on enforcement procedures for OSHA Compliance Safety and Health Officers (CSHOs) during workplace violence inspections. It clarified OSHA policies and procedures related to workplace violence inspections with specific criteria for CSHOs in determining whether to cite an employer for failing to protect its employees from workplace violence in violation of the General Duty Clause.

In 2015, OSHA published *Caring for Our Caregivers: Strategies and Tools for Workplace*
Violence Prevention in Healthcare. This resource provided data and tools to assist healthcare facilities with the development and implementation of safety and health programs addressing a variety of healthcare-based risks, including development of a workplace violence prevention program, specifically.

In 2016, OSHA revised its Guidelines for Preventing Workplace Violence for Healthcare and Social Assistance Workers. This version addressed risk factors within specific sectors of healthcare and social services, including:

- Hospital settings;
- Residential treatment settings including institutional facilities such as nursing homes, and other long-term care facilities;
- Non-residential treatment/service settings including small neighborhood clinics and mental health centers;
- Community care settings including community-based residential facilities and group homes; and
- Field-based work settings including home healthcare workers or social workers who make home visits.

In 2017, OSHA issued Directive CPL 02-01-058, Enforcement Procedures and Scheduling for Occupational Exposure to Workplace Violence, a guidance document for its CSHOs when conducting workplace violence investigations. This revision to the previous Directive CPL 02-01-052 from 2011 clarified the different types of healthcare settings where workplace violence incidents are reasonably foreseeable. It also identified steps employers can take to reduce the workplace violence hazard.

Despite the quantity of guidance and the enforcement activities OSHA has pursued, both OSHA’s Fatality and Catastrophe Investigation Summaries and BLS’s Census of Fatal Occupational Injuries (CFOI) show an increase in the number of workplace violence-related fatalities among health care and social assistance workers between 2018 and 2020. These two sources of data differ in that Fatality and Catastrophe Investigation Summaries are developed solely after OSHA conducts an inspection in response to a specific fatality or catastrophe. By contrast, BLS CFOI data are a more representative sample of data since they are comprised of reports for all fatal work injuries as long as the decedent was engaged in an activity related to work, regardless of whether the decedent was working in a job covered by OSHA or another federal or state agency.

OSHA Information System (OIS) data from fatality inspections showed an increase from five workplace violence-related deaths in 2018 to ten deaths in 2020 (100 percent increase). CFOI data showed an increase from 36 deaths in 2018 to 52 deaths in 2019 (44 percent) (BLS, CFOI, 2019)
OSHA has long considered the appropriateness of regulatory action to address workplace violence. OSHA has received recommendations to issue a rule on workplace violence in the healthcare and social assistance sector. For instance, in GAO’s 2016 report “Workplace Safety and Health: Additional Efforts Needed to Help Protect Healthcare Workers from Workplace Violence,” GAO recommended that OSHA consider whether additional action, such as developing a standard, is needed.

In 2016, OSHA published a Request for Information (RFI) Preventing Workplace Violence in Healthcare and Social Assistance. Prevention of Workplace Violence in Healthcare and Social Assistance, 81 Fed. Reg. 88147 (Dec. 7, 2016). OSHA received over 150 comments from the public in response to the RFI document. Comments were submitted from a range of organizations and individual respondents with interest and expertise in healthcare and social assistance. Overall, OSHA received strong support for proceeding with the rulemaking process for a potential standard on preventing workplace violence in Healthcare and Social Assistance, including from commenters such as The American Association of Occupational Health Nurses, Inc. (AAOHN) (Ex. 0168), the American Federation of State County and Municipal Employees (AFSCME) (Ex. 0234), The United Steelworkers (Ex. 0210), the Service Employees International Union (SEIU) (Ex. 0236), and multiple state level associations (Ex. 0239, 0233, 0234, 0215, 0095, 0241, and 0111). The need to protect healthcare workers from violence was the most frequently recurring reason stated for supporting the potential rule in the comments submitted in response to the RFI.

Multiple public interest, professional, worker advocacy, and governmental organizations have also recommended OSHA consider regulatory action to address the workplace violence hazard. In 2013, Public Citizen published “Health Care Workers Unprotected: Insufficient Inspections and Standards Leave Safety Risks Unaddressed,” which recommended OSHA promulgate a workplace violence standard. The Joint Commission, which recently added workplace violence prevention elements to their standards for several areas of evaluation criteria chapters, said “The Joint Commission…welcomes the approach of a[n OSHA] workplace violence standard, guidance, and tool kits.” (Ex. 0221)

10 In the absence of federal regulatory action, multiple states have issued regulations to address the workplace violence hazard in the healthcare industry. Ten states have enacted laws that require healthcare employers to establish a workplace violence prevention plan or program: California (Title 8 Section 3342, 2016), Nevada (Assembly bill 348, 80 Cong. 2019), Connecticut (Public Act No. 11-175, Substitute Bill 970, 2011), Illinois (405 ILCS 90, 2013, 210 ILCS 160/2019), Maine (22 MRS § 1832, 2011) Maryland (SB 483, 2014), New Jersey (P.L Chapter 236, 2008), New York (12 NYCRR Part 800.6, 2007), Oregon (Chapter 654, 2017) and Washington (Title 49, Chapter 49.19RCW, 1999). California became the first state to adopt an occupational health and safety standard requiring healthcare facilities to take certain specific steps to establish, implement, and maintain an effective workplace violence prevention plan. Louisiana, Nevada, and Illinois recently enacted similar regulations to require certain in healthcare employers to create and implement unit-specific workplace violence prevention programs and to report incidents.
OSHA received two workplace violence rulemaking petitions in 2016, one from a coalition of labor organizations (American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), American Federation of Government Employees (AFGE), AFSCME, SEIU, Teamsters and United Steelworkers, and American Federation of Teachers (AFT)), and the other from the National Nurses United (NNU). OSHA granted the rulemaking petitions on January 10, 2017, stating that “workplace violence is a serious occupational hazard that presents a significant risk for healthcare and social assistance workers” and that a workplace violence standard “is necessary.”

Based on the evidence that OSHA has collected through years of enforcement activities, analysis of BLS data and occupational injury literature, as well as continued stakeholder input, OSHA has concluded that the issue of workplace violence in healthcare and social assistance settings is a serious problem that puts millions of U.S. workers at increased risk of injury.

OSHA preliminarily believes that development and enforcement of a workplace violence standard would reduce the risk of workplace violence in the healthcare and social services industry. A workplace violence standard would help to clarify employer obligations and the measures necessary to protect employees from such violence. OSHA’s enforcement experience indicates that addressing hazards through rulemaking, rather than through enforcement of the general duty clause, more efficiently and effectively reduces risk. OSHA has concluded that there is a need to initiate the rulemaking process for a standard intended to reduce the risk of physical harm to employees working in healthcare and social assistance sectors.

The Measures in This Draft Standard Would Considerably Reduce the Risk of Workplace Violence in the Healthcare and Social Assistance Industry

General Structure of the Proposed Regulation

OSHA’s draft regulatory framework addresses, and aims to reduce, the prevalence and the severity of workplace violence in health care and social assistance settings. For the purpose of this potential standard, OSHA focuses solely on type II workplace violence, which are violent acts committed by patients, clients, and their visitors upon workers within a healthcare or social assistance setting. OSHA is defining “workplace violence incident” as any violent act (including physical assault and threat of physical assault) directed toward persons at work or on duty by patients, clients, or their visitors. These incidents may or may not result in injury. Examples of physical assaults include slapping, beating, rape, homicide, and the use of weapons such as firearms and knives. Threats of physical assaults include expressions of intent to cause physical harm, either verbal, written, or through body language.
The agency is therefore considering to propose an occupational safety rule on employee exposure to workplace violence. Some recognized risk factors for workplace violence in healthcare and social assistance, from the OSHA *Guidelines for Prevention of Workplace Violence in Healthcare and Social Assistance*, include:

- Direct patient care;
- Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff;
- Poor environmental design of the workplace that may block employees’ vision or interfere with their escape from a violent incident;
- Lack of means of emergency communication;
- Inadequate security;
- Unrestricted movement of the public in clinics and hospitals; and
- Working alone in a facility or in patients’ homes.

To address such risk factors, OSHA’s draft standard uses a programmatic, performance-based approach with a series of provisions that would require employers to develop and implement workplace violence prevention policies and involve employees in the creation and implementation of a workplace violence prevention program. Employers would be required to perform regular hazard assessments based on their own injury records as well as identify and mitigate hazards in the work environment and hazards associated with work practices. OSHA is considering training requirements for employees and their supervisors, a specific workplace violence recordkeeping log, incident investigation procedures, and an anti-retaliation policy to encourage employee reporting of workplace violence incidents.

The five core components of a workplace violence prevention program identified in OSHA’s “Guidelines for Preventing Workplace Violence for Healthcare and Social Services Workers”— (1) Management Commitment and Employee Participation; (2) Worksite Analysis and Hazard Identification; (3) Hazard Prevention and Control; (4) Safety and Health Training; (5) Recordkeeping and Program Evaluation—are also the five core components upon which OSHA has established the framework for this draft regulation. Research indicates that such measures can meaningfully reduce workplace violence in healthcare. When hospitals or social service organizations have adopted similar programmatic performance-based approaches, they have recorded a reduction of workplace violence incidents.

The literature supports this approach. For instance, Noga, et al., 2020, described how, in its efforts to have more regulatory oversight of workplace violence in healthcare, the Massachusetts Health & Hospital Association developed a 5-step continuous process improvement plan based largely on OSHA’s workplace violence guidelines. The plan included identifying issues, receiving stakeholder input, collecting and sharing data and information statewide, and creating
guidelines for hospitals. The authors found this represented a serious statewide investment in preventing workplace violence, collecting and reviewing data, and improving established interventions in hospital settings (Noga, et al., 2020). Additionally, Nevels, et al., discussed H.R. 1309, a bill in Congress that mirrors much of OSHA’s draft standard, and argued that the approach outlined in the bill was a significant improvement over enforcement through the General Duty Clause. (Nevels, et al., 2020).

**Programmatic Approach with Management Commitment and Employee Involvement**

The programmatic approach that OSHA is considering in this draft standard for prevention of workplace violence in healthcare and social assistance settings is consistent with the principles of the International Labour Organization’s Convention No. 190 – Eliminating Violence and Harassment in the World of Work (ILO, 2019). OSHA believes that this programmatic approach for promotion of management commitment and employee involvement will promote a safety culture in covered establishments. The leadership of management in providing full support for the development of the workplace’s program, combined with worker involvement, is critical for the success of the program.

The American Nurses Association (ANA) supported this approach, noting that it is critical for both RNs and their employers to be involved in developing, implementing, and improving workplace violence prevention programs (Ex. 0162). The International Association for Healthcare Security & Safety (IAHSS) also supported this concept and referred to its Guideline 01.09 *Violence in Healthcare* that recommends “a multidisciplinary team that includes representatives from security, clinical, risk management, human resources, ancillary/support staff, executive leadership, and external responders, as appropriate, to develop and maintain the workplace violence program and prevention strategies.” It stated that participation and collaboration within the framework of a multidisciplinary approach helps “to guide the organization’s development of safety, security, and workplace violence prevention and response plans” (Ex. 0151).

Through involvement and feedback, workers can provide useful information to employers to design, implement and evaluate the program. In addition, workers with different functions and at various organizational levels bring a broad range of experience and skills to program design, implementation, and assessment.

**Worksite Analysis and Hazard Identification, Prevention, and Control**

A worksite analysis involves a step-by-step assessment of the workplace to find existing or potential hazards that may lead to incidents of workplace violence. The assessment should include a records review, a review of the procedures and operations for different jobs, employee surveys and workplace security analysis. Once the worksite analysis is complete, it should be
used to identify the types of hazard prevention and control measures needed to reduce or eliminate the possibility of a workplace violence incident occurring. In addition, it should assist in the identification or development of appropriate training. Employee questionnaires or surveys are effective ways for employers to identify potential hazards that may lead to violent incidents, identify the types of problems workers face in their daily activities, and assess the effects of changes in work processes.

The literature supports this kind of worksite analysis. For example, Arnetz et. al. (2017) conducted a study within a multi-site hospital system in the Midwest United States that had approximately 15,000 employees and an electronic database for reporting workplace violence. The study involved the authors first analyzing data from prior workplace violence incidents to determine what hospital units had high rates of violence and then conducting walkthroughs with supervisors and staff members to identify interventions, which resulted in the supervisors developing an action plan. The action plans included interventions such as security assessments of units and recommendations for shortcomings from hospital safety staff; monthly meetings with hospital safety staff, occupational health and safety staff, and security staff; increased frequency of security rounds; de-escalation trainings; installation of panic alarms; increased lighting in surrounding parking lots; active shooter trainings; and more balanced scheduling of staff in general. The authors concluded that this approach was effective in decreasing the risk of patient-on-worker violence and injury.

Okundolor, et. al. (2021) described a large urban academic hospital that evaluated baseline data and issues in the hospital and developed an action plan based on that analysis. The action plan involved a variety of interventions: “(1) increasing behavioral response team drills, (2) implementing [preshift briefings for staff on each patients’ behaviors and propensity for violence], (3) screening for patients’ risk for violence, (4) posting signage to communicate patients’ violence propensity, (5) implementing mitigating countermeasure interventions, (6) conducting post-assault debriefing, and (7) providing post-assault support.” Staff perceived self-efficacy increased from 78 percent to 95 percent after attending at least two behavioral response team drills. Physical assaults on staff by patients decreased to zero in this psychiatric ER, which was sustained for one year. (Okundolor, et al., 2021).

Drummond et. al described the success experienced by one general hospital in reducing violent behavior when it first tracked data regarding repeated violence of patients and then used that data to identify and manage high-risk patients through the use of computerized warnings or “flags” on patient charts. The number of incidents declined by 91.6 percent and visits by employees to the medical center for any reason decreased by 42.2 percent. (Drummond, et. al. 1989).

Worksite analysis and hazard identification require employers to examine the relationship between employees, tasks, tools, and the work environment. This involves reviewing the
procedures and operations connected to specific tasks or positions to identify hazards related to workplace violence and then modifying those procedures and operations to reduce the likelihood of violence occurring. OSHA believes that employers that comply with the hazard assessment and control measure provisions in this draft standard can achieve significant reductions in the rates and severity of workplace violence incidents.

Safety and Health Training

Education and training are key elements of a workplace violence prevention program, and help ensure that all staff members are aware of potential hazards and how to protect themselves and their coworkers through established policies and procedures. Training topics included in OSHA’s draft standard include de-escalation and management of assaultive behavior, as well as personal safety training on how to prevent and avoid assaults and training that covers the policies and procedures associated with all aspects of an employer’s workplace violence prevention program (WVPP).

National Nurses United highlighted the importance of in-person and hands-on training that discusses the WPV hazards that employees may encounter in the course of their jobs. In addition, they stated that training should address prevention measures, and the policies, procedures, and communication methods established by the employer regarding WPV. National Nurses United also advocated for all employees to receive an initial training when the employer’s WPV prevention plan is first established, upon hire, or upon assignment to new duties for which training was not previously provided. WPV prevention training should have an interactive format where questions are answered by a person knowledgeable about the topic.

Studies have indicated the effectiveness of training. For example, a sample of 255 home healthcare workers completed a case-controlled study associated with computer-based training (CBT) on WPV prevention. 129 participants took the CBT supplemented with peer support and facilitation and the other 126 took the CBT only. The authors found that training participants, controlling for group, exhibited an increase in workplace violence knowledge and awareness, (they “significantly improved from a mean of 70.6 percent correct responses in the pre-test to a mean of 91.4 percent correct responses on the immediate post-test”). All participants experienced a statistically significant increase in their confidence to respond to workplace aggression. All participants also reported a decline in workplace violence, including sexual harassment and verbal aggression. (Glass, et al. 2017).

Education and training ensure that employees, supervisors, and managers are able to recognize and control hazards, allowing them to work more safely and contribute to the development and implementation of the workplace violence prevention program. OSHA believes that training provides employers, managers, supervisors, and employees with the knowledge and skills needed
to do their work safely and to avoid creating hazards that could place themselves or others at risk, as well as awareness and understanding of workplace violence hazards and how to identify, report, and control them.

*Incident Investigation, Recordkeeping, Program Evaluation, and Preventing Retaliation*

Incident investigation, recordkeeping and evaluation of the violence prevention program are necessary to determine its overall effectiveness and identify any deficiencies or changes that should be made. Post-incident investigation and evaluation are important components to an effective violence prevention program. The thorough investigation of incidents of workplace violence will provide a roadmap to avoiding fatalities and injuries associated with future incidents. The purpose of the investigation should be to identify the “root cause” of the incident. Records can be especially useful to large organizations for this purpose and may include:

- The OSHA Log of Work-Related Injuries and Illnesses (OSHA Form 300),
- Medical reports of work injury, workers’ compensation reports and supervisors’ reports for each recorded incident,
- Records of reports conducted by security personnel in response to verbal attacks or aggressive behavior that may be threatening,
- Documentation of minutes of safety meetings,
- Records of hazard analyses and corrective actions recommended and taken, and
- Records of all training programs, attendees, and qualifications of trainers.

OSHA has also included an anti-retaliation provision in the draft standard so that employees who may perceive that they may be punished for reporting incidents will feel more secure in doing so.

OSHA’s draft standard includes a specific Workplace Violence Incident Log that the agency expects would be particularly useful for this purpose. The studies conducted by Arnetz et. al. (2017), Okundolor, et al., (2021), and Drummond, et. al. (1989), summarized above, demonstrate the importance of accurate recordkeeping and evaluation with respect to hazard assessment, implementation of control measures, and program evaluation to reduce the risk of workplace violence.

The International Association for Healthcare Security & Safety (IAHSS) supports this kind of program, and has recommended that all workplace violence threats be reported, documented, reviewed, and assessed to determine opportunities for improvement (Ex. 0151). OSHA believes it is important that responsible parties (including managers, supervisors and employees) reevaluate policies and procedures on a regular basis to identify deficiencies and take corrective action.
Based on these studies and the evidence presented by stakeholders, OSHA believes that the measures in the draft standard would considerably reduce the risk of workplace violence faced by workers in the healthcare and social assistance industries. In the following pages, Sec IV-Draft Regulatory Text presents additional details with regard to the provisions included in OSHA’s draft regulatory text. OSHA welcomes SER feedback with respect to the specific provisions in the draft.
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Section IV-a. Prevention of Workplace Violence in Healthcare and Social Assistance Draft Regulatory Text

29 CFR 1910.1031

(a) Scope and Application. This standard applies to all employers with employees that work in:

(i) Hospitals, including emergency departments;
(ii) Psychiatric hospitals and residential behavioral health facilities;
(iii) Ambulatory mental healthcare and ambulatory substance abuse treatment centers;
(iv) Freestanding emergency centers;
(v) Residential care facilities;
(vi) Home healthcare;
(vii) Emergency medical services; and
(viii) Social assistance (excluding child day care centers).

(b) Definitions. For the purposes of this standard, wherever the terms below are used, they are defined as follows:

*Alarm* means a mechanical or electronic device by which employees can summon assistance to respond to an actual or potential workplace violence emergency. Such devices include wall or desk-mounted panic alarm buttons, personal panic alarm buttons, emergency alarms, or other two-way mobile monitoring personal emergency communications devices that do not rely upon employee vocalization/shouting for assistance.

*Ambulatory mental healthcare facilities* mean facilities such as offices of psychiatrists, psychologists, mental health specialists, mental health practitioners, or substance abuse centers that provide mental health services primarily on an outpatient basis.

*Designated program administrator* means an individual designated by the employer to provide logistical oversight and to be responsible for the coordination and management of the administrative and technical oversight for all elements of the workplace violence prevention program (WVPP). The designated program administrator must have the knowledge, skills, or training to implement and oversee the program effectively. If the designated program administrator does not have the knowledge, skills, or training necessary to implement and oversee the program effectively, then they must consult with appropriate personnel who have such knowledge, skills or training to ensure that the WVPP is implemented and overseen effectively.

*Direct patient/client/resident care* means job duties that involve the delivery of healthcare services or social assistance services with hands-on or face-to-face contact with patients/clients/residents. Employees who provide direct patient/client/resident care include nurses, physicians, nursing assistants, patient care assistants, technicians, and other healthcare workers, social workers visiting client homes, as well as employees providing emergency medical services.

*Direct patient/client contact* means job duties where employees perform support work that requires them to be in patient care areas. Such work includes environmental services, engineering services, laundry services, meal delivery, information technology, and others. For purposes of SBREFA, OSHA also considers security staff to belong in this category.
Emergency medical services mean paramedics, emergency medical technicians (EMTs), and firefighters cross-trained and performing services as paramedics or EMTs.

Engineering Controls mean a physical aspect of the built space or a device that removes or reduces a hazard, or creates a barrier between an employee and the hazard. Some examples of engineering controls include access controls to employee-occupied areas, metal detectors (installed or handheld), enclosed workstations with shatter-resistant glass, deep service counters or other means to physically separate patients/clients/residents and their visitors from employees, separate or isolation rooms or treatment areas for patients with a history of violence, locks on doors, removing access to or securing items that could be used as weapons, affixing furniture to the floor, closed-circuit television monitoring and video recording, other means of assuring visibility such as mirrors and improved illumination, and personal alarm devices.

Environmental risk factor means a risk factor that is attributable to the layout, design, and amenities of the physical workspace or the community wherein services are provided, including work in neighborhoods with high crime rates.

Establishment means a single physical location where business is conducted or where services or industrial operations are performed. For activities where employees do not work at a single physical location, such as emergency medical services or home healthcare, the establishment is represented by main or branch offices that either supervise such activities or are the base from which personnel carry out these activities.

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

Home healthcare and field-based social assistance means care or services provided at the patient/client/resident’s residence or other site of care where the patient/client/resident may temporarily reside such as a rehabilitation center or group home.

Host employer means an employer that owns, operates, or controls the operation of a fixed-establishment work setting (e.g., hospital, behavioral health center).

Individual Responder means an employee designated to respond to workplace violence incidents who has received an advanced level of instruction for response.

Organizational risk factor means a factor resulting from the policies, procedures, work practices, or culture of the organization. Examples include working when understaffed, high employee turnover, unrestricted movement of the public in clinics and hospitals, the perception that violence is tolerated within the organization, the patient/client/resident mix, and nature of services provided.

Psychiatric hospital means a hospital primarily engaged in providing diagnostic, medical treatment, and monitoring services for in-patients with acute mental illness or substance abuse disorders. The treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements.

Residential behavioral health facilities mean facilities primarily engaged in providing residential care and treatment for patients with chronic mental health and substance abuse illnesses.
These facilities provide room, board, supervision, and counseling services. Although medical services may be available at these establishments, they are incidental to the counseling, mental rehabilitation, and support services offered. These establishments generally provide a wide range of social services in addition to counseling.

**Residential care facilities** mean facilities that provide residential care combined with either nursing, supervisory, or other types of assistance as required by the residents. These establishments include those engaged with providing nursing home services for elderly and rehabilitative clients, and assisted living for the elderly. These establishments provide room, board, supervision, and counseling services. Although medical services may be available at these establishments, they are incidental to the primary support services offered.

**Triage** means the area(s) of admission at an emergency department or other site where emergency medical services are provided where a determination is made by a healthcare professional of medical urgency of wounds or illness to decide the order of treatment for patients.

**Vendor** means an individual or company that sells goods or services on an ongoing basis at a healthcare or social assistance establishment.

**Violent Incident Log** means the systematic and ongoing documentation of each incident reported through the violent incident reporting system.

**Violent Incident Report** and **Violent Incident Reporting System** mean the individual report filed in response to a violent incident and the system implemented by the employer to collect the details of each report, respectively.

**Workplace violence incident** means any violent act (including physical assault and threat of physical assault) directed toward persons at work or on duty by patients or their visitors. It may or may not result in injury.

**Workplace violence response team** means a group of employees designated to respond to violent incidents. They have advanced levels of training and do not have other assignments that would prevent them from responding immediately to an alarm to assist other staff.

**Work practice controls** mean policies and procedures that reduce the likelihood of workplace hazards. These controls include maintaining sufficient staff for the hazard, and providing training on de-escalation techniques and how to respond to workplace violence.

### (c) Workplace Violence Prevention Program (WVPP)

1. **General.** Each employer must develop, implement, and maintain a written workplace violence prevention program (WVPP).

2. **Elements of the WVPP.** The WVPP must contain at least the following elements:
   - (i) A copy of the workplace hazard assessment as required in paragraph (d), Table E-1, or Table E-2, as applicable.
   - (ii) All standard operating procedures associated with the development and implementation of workplace violence control measures to address identified workplace violence hazards or risk factors as required in paragraph (e), Table E-1, or Table E-2, including written records of controls implemented, as applicable.
   - (iii) All standard operating procedures and policies associated with recording, reporting, and investigating violent incidents as required in paragraph (g).
   - (iv) A copy of the employer’s anti-retaliation policy, as required in paragraph (i).
   - (v) Procedures to effectively communicate and coordinate with other employers at the same
worksite:

(A) Host employers must include a description of procedures to protect employers on-site (e.g. contractors, vendors, staffing agencies, and licensed independent practitioners with privileges) from workplace violence hazards.
(B) The host employer must ensure that other employers on-site adhere to the host employer’s WVPP.
(C) The host employer must establish procedures to facilitate communication regarding the implementation of the WVPP between the host employer and other employers on-site.
(D) Other employers on a multi-employer worksite must include a description of how their WVPP coordinates with that of the host employer.

(vi) Procedures to involve non-managerial employees and their representatives (if applicable) in developing, implementing, and reviewing the WVPP, including their participation in:
(A) Identifying, evaluating, and correcting workplace violence hazards;
(B) Designing and implementing training and reporting procedures;
(C) Investigating workplace violence incidents; and
(D) Annually reviewing the WVPP.

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

(3) **Review of the WVPP.** The WVPP must be reviewed and updated at least annually and whenever necessary to reflect changes in the workplace, including a change in population, services provided, or the investigation of violent incidents, that indicate a need to revise policies to address employee exposure to workplace violence.

(i) The program review must be conducted by a team consisting of management, non-managerial employees, and their employee representatives (if applicable).

(ii) Employers must establish and maintain written records for each review and/or update of the WVPP.

(iii) The team must evaluate records and information pertaining to the implementation and effectiveness of the WVPP.

(4) **Employee Involvement.** Employers must allow sufficient paid time for employees to complete any required WVPP activities (e.g., training, reporting, incident reviews, etc.) at a reasonable time and location.

(5) Employers must notify all employees of the existence and contents of the WVPP, how to report violent incidents, and whom to contact with questions via postings in areas accessible to all employees.

**d) Workplace violence hazard assessment.**

(1) Assessment of risk factors throughout the establishment. Each employer must conduct an assessment to identify environmental and organizational risk factors throughout the establishment. The employer must:
(i) Provide an opportunity for employees to report all workplace violence incidents that occurred in the establishment in the previous three years.

(ii) Record all previously unreported workplace violence incidents in the establishment in the previous three years.

(iii) Review all workplace violence incidents in the establishment in the previous three years.

(iv) Evaluate employee risk for workplace violence based on the level and types of crime in the employer’s served community.

(v) Assess all areas of the establishment for the following risk factors:
   (A) Employees with direct patient/client/resident care or contact duties working alone or in remote locations, or during night or early morning hours;
   (B) Locations within the establishment without emergency communication, such as areas where alarm systems are not installed or operational, or where any obstacles and impediments to accessing alarm systems may exist; and
   (C) Ineffective communication mechanisms or practices regarding patient/client/resident status between shifts and between personnel.

(vi) In addition to the hazards and risk factors in (d)(1)(v), at a minimum, the employer must assess all high-risk service areas, as defined in paragraph (b) for the following risk factors:
   (A) Poor illumination or areas with blocked or limited visibility;
   (B) Employee staffing patterns that are inadequate to reduce workplace violence or respond to workplace violence incidents;
   (C) Lack of physical barrier protection between employees and patients/visitors in areas such as admission, triage, and nursing stations;
   (D) Lack of effective escape routes;
   (E) Entryways where unauthorized entrance may occur, such as doors designated for staff entrance or emergency exits; and
   (F) Presence of unsecured furnishings or other objects that could be used as weapons.

(2) Each employer must establish and implement effective procedures to address the findings from the hazard assessments, and maintain written records of the hazard assessments. These procedures must include:

   (i) Identification of high-risk service area(s);
   (ii) Identification of specific hazards or risk factors;
   (iii) A plan to abate the identified hazards or risk factors in an immediate or timely manner during the interim of more permanent abatement;
   (iv) Date(s) the assessment was performed;
   (v) The names and titles of the individuals who participated in the evaluation;
   (vi) Actions planned to address and prioritize mitigation of identified hazards or risk factors permanently;
   (vii) Communication of the status of planned or completed actions to employees who may be affected by the identified hazards or risk factors;
   (viii) The dates by which planned actions are to be completed;
(ix) Written documentation of completed actions including:
   (A) The method(s) of control decided upon;
   (B) Areas where controls were implemented;
   (C) Specific date(s) of completion; and
   (D) The names and titles of the individuals who authorized and managed
       implementation of controls.

(x) Records of workplace violence hazard identification, evaluation, and
    correction must be created and maintained for three years, or for as long as there
    is an unresolved hazard mitigation project pending or still in progress.

(3) **Annual hazard assessments.** Each employer must conduct subsequent hazard assessments
    annually as described in subsection (d)(1).

(4) **Additional hazard assessments.** Each employer must conduct subsequent area-specific
    hazard assessments in response to:
    (i) Workplace violence incidents as specified in paragraph (g)(3)(ii);
    (ii) Physical changes in the layout, design, or amenities of the workplace that could
         increase the risk of workplace violence; or
    (iii) Changes in clientele or services provided that could increase the risk of workplace
         violence.

(5) **Multi-employer worksites.**
    (i) The host employer must conduct the hazard assessment for the establishment.
    (ii) Other employers on a multi-employer worksite who work in a high-risk area must
         coordinate with the host employer to provide any information requested by the host
         employer in order to comply with Paragraph (d).

(6) **Home Healthcare and Field-Based Social Assistance Services.** Paragraphs (d)(1)-
    (d)(5) do not apply to home healthcare and field-based social assistance service
    employers, emergency medical services employers, or staffing agencies. These employers
    must complete the assessments in Table E-1 for Home Healthcare and Field-Based
    Social Assistance Services, or Table E-2 for Emergency Medical Services, as incorporated in
    paragraph (e)(6).

(e) **Control measures.**

(1) Based on the hazard assessments, the employer must establish and implement workplace
    violence control measures to address identified workplace violence hazards or risk factors. Each
    employer must:

    (i) Install, implement, and maintain the use of an effective alarm system for use by
        employees with direct patient/client/resident care or direct patient/client/resident
        contact duties.

    (ii) Establish and implement effective workplace violence incident response
        procedures that include, as applicable:
(A) Standard operating procedures for employees with direct patient care/client care or direct patient/client/resident contact to summon help during a workplace violence incident.
(B) Standard operating procedures for receiving patients/clients/residents who are actively exhibiting violent behavior, including those escorted by law enforcement officers;
(C) Standard operating procedures for staff designated to respond to workplace violence incidents;
(D) If employer uses restraint methods, standard operating procedures for the appropriate use of restraints in accordance with federal, state, and local laws, and ensuring the availability of needed physical and pharmacological restraints, and/or seclusion procedures for high-risk services.
(E) Standard operating procedures to respond to mass casualty threats, such as active shooters; and
(F) Standard operating procedures for obtaining assistance from the appropriate law enforcement agency during all work shifts.

(iii) Establish and implement policies and procedures for employees to document and communicate patient/client/resident specific risk factors to other employees, such as when transporting or receiving patients/clients/residents, and during handoffs between shifts and units. At a minimum, policies and procedures must include:
(A) A patient/client/resident's prior history of violence, to the extent that such history is known to the employer or can be determined by records within the employer’s possession;
(B) Any conditions that may cause the patient/client/resident to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively;
(C) Any recent disruptive or threatening behavior displayed by a patient/client/resident; and
(D) Effective communication via flagging and visible cues of a patient/client/resident’s history or potential for violence on patient charts or client case history for all relevant staff.
(E) For those employees providing direct patient/client/resident/resident care, a patient/client/resident's treatment and medications, type, and dosage, as is known to the health establishment and employees.

(iv) Establish and implement policies and procedures for effective communication of a patient/client/resident’s history or potential for violence to all subsequent external healthcare employers that a patient may be referred to.

(2) Based on the hazard assessment, the employer must implement engineering controls to address identified workplace violence hazards or risk factors in high-risk service areas. At a
minimum, engineering controls must:

(i) Ensure that employees have a clear line of sight in public areas of the establishment, including waiting rooms and hallways, so that employees can observe all activities in areas where members of the public are moving through care or service areas from their work stations without impediment by room design, furniture, and/or other objects. This includes:
   (A) Ensuring no obstructions to line of sight exist;
   (B) Ensuring sufficient illumination;
   (C) Installing surveillance systems or other sight aids such as mirrors;
   (D) Other effective means.

(ii) Ensure that employees have unobstructed access to alarms and exit doors as a means to escape violent incidents.

(iii) Remove, fasten, or secure furnishings and other objects that may be used as improvised weapons in areas where direct patient/client/resident contact/care activities are performed.

(iv) Install protective barriers between employees and patients/visitors in areas such as admission, triage, and nursing stations.

(v) An employer need not implement one of these engineering controls to address the hazard in a particular area if the employer has demonstrated in writing as part of its hazard assessment that the control is not appropriate or feasible for that area.

(3) Additional work practice controls must be implemented in high-risk service areas. At a minimum, work practice controls must include:

(i) Installing, implementing, and maintaining the use of personal panic alarms or other effective means of automated personal emergency communication for employees with direct patient care/direct patient contact duties in high-risk service areas.

(ii) Creating a security policy to address:
   (A) The movement of authorized and unauthorized persons into and throughout the establishment; and
   (B) The movement of authorized and unauthorized weapons into and throughout the establishment.

(iii) Maintaining staff designated to immediately respond to workplace violence incidents in high-risk service areas.

(iv) Ensuring that staffing patterns are sufficient to address the workplace violence hazard. Staffing patterns must account for changes, including: intensity of patients’ needs; the number of admissions, discharges and transfers during a shift; level of experience of nursing staff; layout of the unit; and availability of resources (ancillary staff, technology etc.).

(v) An employer need not implement one of these work practice controls to address a hazard if it demonstrates in writing that the control is not appropriate or feasible for that area.
(4) The employer must provide appropriate personal protective equipment (PPE) such as bite-resistant sleeves or protective facewear at no cost to the employees.

(5) Multi-employer worksites. On multi-employer worksites the host employer must establish and implement all workplace violence control measures.

(6) Home Healthcare and Field-Based Social Assistance Services. Paragraphs (e)(1)—(e)(5) do not apply to home healthcare and field-based social assistance service employers, emergency medical services employers, or staffing agencies. These employers must implement the control measures in Table E-1 for Home Healthcare and Field-Based Social Assistance Services, or Table E-2 for Emergency Medical Services.

**TABLE E-1: Home Healthcare and Field-Based Social Assistance Services – Workplace Assessment and Control Measures**

<table>
<thead>
<tr>
<th>At a minimum, known risk factors to be assessed annually and control methods include:</th>
<th>Control Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(i)</strong> Each employer must: (a) Review all workplace violence incidents within the previous three years; (b) Provide an opportunity for employees to report previously unreported incidents and threats of physical harm, regardless of whether an employee sustained an injury; and (c) Conduct an evaluation of any work practice controls or personal protective equipment implemented to minimize workplace violence hazards.</td>
<td>Based on the review of incidents, the employer must establish and implement the following workplace violence control measures: (a) Standard operating procedures for incident response; (b) Standard operating procedures for obtaining assistance from the appropriate law enforcement agency; (c) Policies and procedures for employees to document and communicate patient/client/resident specific risk factors to other employees, such as during handoffs between shifts; and (d) Provision of personal protective equipment as appropriate.</td>
</tr>
<tr>
<td><strong>(ii)</strong> Employer must assess the adequacy of two-way personal emergency communications devices that can be used by employees to summon aid when working alone with patients/clients/residents.</td>
<td>Employer must provide all employees with working personal emergency communications devices that can be used by employees to summon aid, e.g., cell phones equipped with emergency applications, two-way radios, wearable safety communication devices, etc.</td>
</tr>
<tr>
<td><strong>(iii)</strong> Employer must assess the level and types of crime in the community where services are being provided.</td>
<td>Employer must communicate this information related to the potential for violence in the surrounding community to each employee prior to the employee’s first visit.</td>
</tr>
<tr>
<td><strong>(iv)</strong> Employer must assess the efficacy of its procedures for collecting information concerning</td>
<td>Employer must establish and implement procedures for obtaining and communicating to employees any information concerning a</td>
</tr>
</tbody>
</table>
patients’/clients’ history of violence and the history of violence of anyone else in the household, and the employer’s procedures to provide that information to employees prior to the first visit. 

history of violence by the patient/client/resident or anyone else in the household prior to an employee’s first visit. The employer must document this information in the patient/client/resident’s chart and update the employee if there is any change in status.

(v) Employer must assess whether a clear written safety policy exists to indicate the parameters for an employee to provide services in the presence of potentially violent patients/clients/residents or others. Employer must evaluate whether the policy indicates parameters for when to continue the care visit, summon immediate assistance, or discontinue the visit.

Employer must establish clear, written policies for what employees should do if they feel unsafe, e.g., due to aggressive patients/clients/residents or others in the household. Policies must include when an employee should call for assistance or terminate the visit.

(vi) The employer must evaluate and maintain written records of the review of workplace violence incidents.

The employer must create and maintain written records of workplace violence control measures implemented. Written documentation of the controls implemented must include: (a) The methods of control decided upon; (b) Area(s) where controls were implemented; (c) Date(s) by which the controls will be implemented; (d) Dates that the controls were implemented; and (e) The names and titles of the individuals who authorized implementation of controls. These records must be created and maintained for three years, or for so long as there is an unresolved hazard mitigation project pending or still in progress.

(vii) An employer need not implement one of these workplace violence control measures to address the hazard in a particular area where the employer has demonstrated in writing as part of its review of workplace violence incidents that it is not appropriate or feasible.

TABLE E-2: Emergency Medical Services – Workplace Assessment and Control Measures
| (i) | Each employer must: (a) Review all workplace violence incidents within the previous three years; (b) Provide an opportunity for employees to report previously unreported incidents and threats of physical harm, regardless of whether an employee sustained an injury; and (c) Conduct an evaluation of any engineering controls, work practice controls, or personal protective equipment implemented to minimize workplace violence hazards. | Based on the review of incidents, the employer must establish and implement the following: (a) Standard operating procedures for incident response; (b) Standard operating procedures for obtaining assistance from the appropriate law enforcement agency; (c) Policies and procedures for employees to document and communicate patient/client/resident specific risk factors to other employees; and (d) Provision of personal protective equipment as appropriate. |
| (ii) | Review procedures for obtaining and communicating information regarding environmental risk factors and patient/client/resident risk factors. | Develop procedures for communicating with dispatching authorities to identify any risk factors present at the scene and ensure that appropriate assistance will be provided by cooperating agencies if needed. |
| (iii) | Employer must assess the adequacy of two-way personal emergency communications devices that can be used by employees to summon aid when working with patients/clients/residents. | Employer must provide all employees with working personal emergency communications devices that can be used by employees to summon aid, e.g., cell phones equipped with emergency applications, two-way radios, wearable safety communication devices, etc. |
| (iv) | The employer must evaluate and maintain written records of the review of workplace violence incidents. | The employer must create and maintain written records of controls implemented. Written documentation of the controls implemented must include: (a) The methods of control decided upon; (b) Area(s) where controls were implemented (c) Date(s) by which the controls will be implemented; (d) Dates that the controls were implemented; and (e) The names and titles of the individuals who authorized implementation of controls. These records must be created and maintained for three years, or for so long as there is an unresolved hazard mitigation project pending or still in progress. |
| (v) | An employer need not implement one of these workplace violence control measures to address the hazard in a particular area if the employer has demonstrated in writing as part of its review of workplace violence incidents that it is not appropriate or feasible. |
(f) Training.

(1) The employer must institute a training program for employees, who have direct patient/client/resident contact, provide direct patient/client/resident care, or are responsible for workplace violence incident response duties, and their supervisory staff. Training must be provided to these employees at the following intervals:

(i) Initially, prior to the time of assignment, or when newly assigned to perform duties for which the training required in this subsection was not previously provided;
   (A) If an employee received workplace violence prevention training from the employer in the 12 months preceding the effective date of this standard, the employer need only provide additional training to the extent that the previous training did not meet the requirements of this standard;

(ii) Annually thereafter; and

(iii) Supplemental training to address specific deficiencies when:
   (A) There are changes to any procedures or controls designed to address workplace violence. This training may be limited to addressing only these changes;
   (B) Inadequacies in the employee’s knowledge or work practices indicate that the employee has not retained the requisite understanding or skill; or
   (C) Any other situation that arises in which retraining is necessary to ensure employee protection from workplace violence.

(2) The training program must:

(i) Be overseen or conducted by a person knowledgeable in the program’s subject matter as it relates to the workplace;

(ii) Consist of material appropriate in content and vocabulary to the educational level, literacy, and language of employees;

(iii) Be provided at no cost to employees at a reasonable time and place; and

(iv) Provide an opportunity for interactive questions and answers with a person knowledgeable in the program’s subject matter as it relates to the workplace.

(3) The initial training program must contain content that reflects the level of risk to employees and the duties that they are expected to perform. At a minimum, training for employees with direct patient/client/resident contact duties and their supervisors must contain an introductory/awareness level of instruction on the following elements:

(i) An accessible copy of this standard and an explanation of its contents;

(ii) A general explanation of the risks of workplace violence that employees are reasonably anticipated to encounter in their jobs;

(iii) How to recognize, initiate and respond to specific alerts, alarms, or other warnings about threats of workplace violence;

(iv) The role of security personnel, if any;

(v) How and under which circumstances to report workplace violence incidents to
(vi) An explanation of the employer’s violent incident reporting system and its anti-retaliatory policy;
(vii) Any resources available to employees for coping with workplace violence incidents, such as employee assistance programs;
(viii) Training on all of the standard operating procedures developed as part of the WVPP that are applicable to the employee’s duties;
(ix) Instruction on the use of employer-provided equipment including alarms, communication devices, and personal protective equipment, as well as the limitations of this equipment;
(x) How to recognize threatening behaviors in others, techniques for when and how to safely attempt to de-escalate a violent situation; and
(xi) When and how to seek assistance to respond to potentially escalating violence.

(4) At a minimum, initial training for employees with direct patient/client/resident care duties in areas other than high-risk service areas, and their supervisors, must contain an intermediate level of instruction on the content specified in (f)(3), in addition to:

   (i) An introduction to self-defense strategies and techniques; and
   (ii) How and when to assist others engaged with a violent patient/client/resident or visitor.

(5) At a minimum, initial training for employees with direct patient/client/resident care duties in high-risk service areas, and their supervisors, must contain an intermediate level of instruction on the content specified in (f)(3) and (f)(4), as well as an explanation of the policies and procedures for workplace violence incidents, as well as the demonstration of practical techniques for using them.

(6) Initial training for employees designated to respond to a violent incident and their supervisors, must contain an advanced level of instruction with all elements listed in (f)(3), (f)(4), and (f)(5) and all standard operating procedures that are applicable to the response team, or individual responders, as applicable.

(7) The annual training program must address, at a minimum, the following elements:
   (i) Training on all of the standard operating procedures developed as part of the WVPP that are applicable to the employee’s duties, including any changes to the program that have been made in the past year;
   (ii) An explanation of the employer’s violent incident reporting system, including any changes to the system that have been made in the past year, and results of the review(s) required in subsection (c)(3);
   (iii) Any resources available to employees for coping with workplace violence incidents, such as employee assistance programs; and
   (iv) Employees who received practical training on physical techniques and those employees' supervisors shall be provided refresher training to review the topics included in the initial training.
(8) Training records must be created and maintained for a minimum of one year and include training dates, course contents or a summary of the training sessions, names and qualifications of persons conducting the training, and names and job titles of all persons attending the training sessions.

(g) Violent incident investigation and recordkeeping.

(1) The employer must implement and maintain a written violent incident reporting system for employees to report each workplace violence incident. The violent incident reporting system must include at least the following:

(i) Procedures for employees to promptly report a violent incident, threat of physical harm, or the existence of other workplace violence hazards; and

(ii) Policies and procedures that prohibit the employer, or any other person, from discriminating or retaliating against an employee who reports a workplace violence incident.

(2) Violent Incident Investigation. The employer must establish procedures to investigate the circumstances surrounding each workplace violence incident and obtain information from the employee(s) who experienced or observed the incident.

(i) The employer must initiate an investigation as soon as practicable, but no later than 24 hours after notification that a workplace violence incident has occurred. The employer must conduct an investigation of each incident that includes at least the following:

(A) Review of the circumstances of the incident;
(B) Determination of whether any controls or measures implemented pursuant to the WVPP were ineffective;
(C) Determination of whether additional measures could have prevented the incident;
(D) Determination of whether there is a continuing hazard, and if so, what measures are being taken to protect employees, using modifications of engineering controls, work practice controls, training, or other measures; and
(E) Solicitation of input from involved employees, their representatives (if applicable), and supervisors, about any significant contributing factors to the incident, risk, or hazard, and whether further corrective measures could have prevented the incident, risk, or hazard.

(ii) The employer must document the significant contributing factors, recommendations, and corrective measures taken for each investigation conducted under this paragraph, and incorporate into the annual hazard assessment as required in (d)(4), Table E-1, or Table E-2, as applicable.

(3) Following a workplace violence incident in a service area or activity not previously identified as high-risk, the employer must assess the service area at issue and job functions or activities that may have placed employees at increased risk for workplace violence.
(i) Any service area with a workplace violence incident should be considered high-risk unless there is a written determination of why this designation is not appropriate.
(ii) When a service area is newly-determined to be high-risk, the employer must conduct an reassessment of the area consistent with the assessment in paragraphs (d)(1)(iv) and implement the controls identified in (e)(2) through (e)(3). The assessment must be conducted within 30 days unless the employer demonstrates it is infeasible, in which case it must be completed as soon as possible.

(4) Violent incident log: The employer must establish and maintain records of each workplace violence incident, by establishment or by relevant patient/client/resident care unit, regardless of whether the incident meets the criteria for an OSHA recordable injury or illness under 29 CFR Part 1904.

(i) Multi-employer worksites. The host employer must record violent incidents affecting any contractors, vendors, staffing agencies, and licensed independent practitioners with privileges operating in the establishment.
(ii) The violent incident log must include, at a minimum:
   - Employee’s name(s);
   - Hire date(s);
   - The date, time, and location of the incident, and job titles of involved employee(s);
   - A detailed description of the incident;
   - A description of risk factors present at the time of the incident (e.g., whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, in a high crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances);
   - The nature and extent of the employee’s injuries, if any;
   - Whether the incident required medical attention;
   - Whether there was injury requiring days away from work;
   - Name of person(s) who committed the violence;
   - Classification of the person(s) who committed the violence, including whether they were a patient or client, family member or associate of a patient or client, or any other appropriate classification;
   - Information about the person completing the log including their name, job title, phone number, email address, and the date completed.

(iii) The following information from the violent incident log must be available upon request to all employees:
   - The nature and extent of the employee’s injuries, if any;
   - A detailed description of the incident;
   - The date, time, and location of the incident, and job titles of involved employee(s); and
   - A description of risk factors or other circumstances at the time of the incident.
   - Classification of the person(s) who committed the violence, including whether they were a patient or client, family member or associate of a patient or client, or
any other appropriate classification.

(F) This information relating to employee health must be used in a manner that protects the confidentiality of employees to the extent possible. The employer must omit any element of personal identifying information sufficient to allow identification of any person involved in a workplace violence incident, such as the person's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the person's identity.

(h) Retention of records.

(1) Access to records. All records required by this section shall be provided upon request to employees, representatives designated by an individual employee, and the Assistant Secretary within the next business day.

(i) Records of annual WVPP reviews as required by paragraph (c) must be created and maintained for a minimum of three years.

(ii) Records of workplace violence hazard assessment and control measures as required in paragraphs (d) and (e), Table E-1, or Table E-2, as applicable, must be created and maintained for three years, or for as long as there is an unresolved hazard mitigation project pending or still in progress.

(iii) Training records as required in paragraph (f) must be created and maintained for a minimum of one year.

(iv) Records of violent incidents, including violent incident investigation reports and violent incident log reports required by this paragraph must be created and maintained for a minimum of three years.

(A) Establishment-wide violent incident records shall be provided to the Assistant Secretary upon request.

(B) Establishment-wide violent incident log reports, excluding employee names, contact information, and occupations, shall be provided to all of the following: any employees, their personal representatives, and their authorized representatives.

(C) Violent incident records relating to a particular employee shall be provided to that employee and to anyone having written authorized consent of that employee.

(Note to paragraph (h): The violent incident investigation reports and violent incident logs shall not replace the employer’s obligations to comply with 29 CFR Part 1904. Injuries or illnesses that occur as a result of workplace violence may be recordable on the OSHA 300 log.)

(i) Anti-retaliation.

(1) The employer must inform each employee that:

(i) employees have a right to the protections required by this section; and

(ii) employers are prohibited from discharging or in any manner discriminating against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.
(2) The employer must not discharge or in any manner discriminate against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.

Note to paragraph (i): In addition, section 11(c) of the OSH Act also prohibits the employer from discriminating against an employee for exercising rights under, or as a result of actions that are required by, this section. That provision of the Act also protects the employee who files a safety and health complaint, or otherwise exercises any rights afforded by the OSH Act.

(j). Effective Date of the Standard. (1) All the provisions of the final standard will become effective sixty days after the publication date of the final standard.
(2) Employers shall comply with all provisions of the final standard within six months after the publication date of the final standard.
Section IV-b. Summary of the Draft Regulatory Text for Prevention of Workplace Violence in Healthcare and Social Assistance

OSHA has developed the following summary of the draft regulatory text for a workplace violence prevention rule, which explains OSHA’s current thinking on the elements that a proposed rule may contain. As described earlier, the regulatory text included is a draft to provide descriptive information and to solicit feedback from small entity representatives. All references made to regulatory text are addressing this working draft.

(a) Scope.

Paragraph (a) of the draft regulatory text covers the scope of the draft rule. The evidence that OSHA has reviewed so far suggests that healthcare and social assistance service workers face significant risks of job-related violence. Workplace violence affects a myriad of healthcare and social assistance workplaces, including psychiatric facilities, hospitals, emergency departments, community mental health clinics, ambulatory substance abuse treatment centers, residential care facilities, home healthcare, and emergency medical services (EMS).

In order to prevent incidents of workplace violence in healthcare and social assistance settings, the draft regulatory text would cover all employers with employees who work in:

- Hospitals, including emergency departments;
- Psychiatric hospitals and residential behavioral health facilities;
- Ambulatory mental health care and ambulatory substance abuse treatment centers;
- Freestanding emergency centers;
- Residential care facilities;
- Home health care;
- Emergency medical services (including firefighters cross-trained to provide emergency medical services); and
- Social assistance (excluding child day care centers).

OSHA recognizes that the social assistance sector includes a broad spectrum of employers. Employers in this sector may provide individual and family services from a fixed location such as service center or a hospital, or also in patient/client/resident homes or another off-site location. Social assistance employers that provide services in a fixed establishment may operate their own centers or shelters, or they may subsidize housing used for clients in need. There are a wide variety of employers and services provided within the social assistance sector, and OSHA seeks to engage with SBAR panel participants to better identify and understand the employers in this sector, the services they provide, and the areas where violence prevention programs could be most effective.

All employers with employees who work in facilities as described in the scope of this draft rule would have to develop, implement, and maintain a written workplace violence prevention
program (see paragraph (c)), conduct a hazard assessment (see paragraph (d)), implement control measures (see paragraph (e)), provide training (see paragraph (f)), investigate workplace violence incidents and maintain records (see paragraphs (g) and (h)). The agency has chosen the sectors listed above because OSHA’s experience, BLS data, and the best available epidemiological literature consistently demonstrate that the sectors described above have the highest potential risk for workplace violence. OSHA welcomes feedback from the Small Entity Representatives (SERs) on the draft scope of the standard.

(b) Definitions.

Paragraph (b) of the draft regulatory text covers the draft rule’s definitions. OSHA has determined that employees most at risk of workplace violence are those performing healthcare services or social assistance services with hands-on or face-to-face contact with patients (defined as “direct patient/client/resident care” in paragraph (b) of the draft regulatory text). They include nurses, physicians, and other healthcare workers, social workers visiting client homes, as well as employees providing emergency medical services.

Employees who perform support work that requires them to be in patient/client/resident care areas (defined as “direct patient/client/resident contact” in paragraph (b) of the draft regulatory text) are also at risk. This work includes housekeeping, maintenance, meal delivery, and information technology. For purposes of SBREFA, OSHA also considers security staff to belong in this category. Each covered employer would need to determine whether employees provide direct patient/client/resident care, have direct patient/client/resident contact, have workplace violence incident response duties, or supervise such staff. These duties are relevant to the type of training that is needed (see paragraph (f)).

While security guards supporting healthcare or social services may also have significant exposure to patients during a response to an incidence of violence in a manner that increases the risk of injury because of the type of interaction, the draft standard does not group them with the direct care providers that are also at high-risk. Security guards are grouped with the “contact” group of employees. OSHA expects security guards to be trained effectively by their employers on the proper response to violent incidents because those incidents constitute a recognized hazard of that type of employment and part of the function of those employees is to resolve those incidents.

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

- Patient/Client/Resident Care Employees accounted for 78 percent of WPV injuries;
• Patient/Client/Resident Contact Employees accounted for 20 percent of WPV injuries; and

• All other occupations in healthcare and social assistance accounted for 2 percent of WPV injuries.

OSHA notes that BLS data are not broken down so neatly as to provide precise numbers to work with, but for discussion’s sake during this SBREFA process, these may be reasonable estimates to work with. (BLS Special Run Data for Number of WPV Injuries by Occupation within Healthcare and Social Assistance, 2019)

This draft standard is focused on controls and other prevention measures for workers engaged in healthcare or social services who, absent this standard, may not be properly trained or protected from workplace violence incidents. OSHA requests feedback from SERs regarding whether security personnel should be subject to additional protections under this standard and, if so, what types of protections. In particular, OSHA requests additional information about the function of security services contracted by healthcare or social service employers and their expected involvement in responses to incidents of workplace violence.

The draft standard requires employers to assess “high-risk service areas” (see paragraph (d)) and implement controls in those areas (see paragraph (e)). “High-risk service area” means settings where there is an elevated risk of workplace violence, and includes emergency rooms/emergency admissions/triage areas, psychiatric care, behavioral healthcare, substance abuse treatment, home healthcare social assistance, and emergency medical services. It also includes an area where a workplace violence incident has occurred in the previous three years unless the employer provides a written determination of why this designation is not appropriate.

The draft regulatory text defines workplace violence incident as “any violent act (including physical assault and threat of physical assault) directed toward persons at work or on duty by patients or their visitors. It may or may not result in injury.” Like the National Institute for Occupational Safety and Health (NIOSH), OSHA has long considered threats of violence to constitute workplace violence due the potential for physical harm.

The draft standard covers employers that directly control their employees’ workplace as well as employers (such as contractors, vendors, and staffing agencies) that have employees who work in a covered sector, even if they do not directly control their employees’ workplace. The draft standard defines “host employer” as an employer that owns, operates, or controls the operation of a fixed-establishment work setting (e.g., hospital, behavioral health center). “Vendor” means an individual or company that sells goods or services on an ongoing basis at a healthcare or social assistance establishment. For example, a hospital may be staffed completely with its own employees or it may contract out certain departments (e.g., an emergency department staffed
with employees from a staffing agency), other services (e.g., environmental services staff, transportation services, or security staff provided by a contractor), as well as perhaps vendors at certain sites (e.g. gifts, sundries, florists, and public food services).

(c) Workplace Violence Prevention Program (WVPP). Paragraph (c) of the draft standard requires each employer to develop, implement, and maintain a written workplace violence prevention program. This would be a program-oriented standard, which would allow the employer to tailor the specific regulatory requirements to their own establishment, while not eliminating any items when converting to their own use. The program would be required to contain all elements required by the WVPP, but can be written and implemented in a way that employers and their employees can best suit to their workplace. Employers would have the flexibility to tailor the plan and its implementation to specific workplace conditions and hazards. OSHA has enacted other program standards for healthcare industries in the past, such as the Bloodborne Pathogens standard, 29 C.F.R. § 1910.1030, and the Respiratory Protection standard, 29 C.F.R. § 1910.134. Eleven states also require healthcare employers to develop and implement a workplace violence prevention plan.

The plan would be in effect at all times and be specific to the hazards and any corrective measures associated with those hazards for each establishment. A written plan is necessary to allow employees working on all shifts to refer to procedures that must be followed for optimal prevention and response to incidents of workplace violence. The requirements of the WVPP would allow the written plan to be incorporated into any existing injury and illness prevention program that the employer may already have in place, or to be kept as a separate standalone document.

The WVPP would focus on developing processes and procedures appropriate and specific for the size and complexity of the specific establishment’s operation or work setting. OSHA expects that a written program for workplace violence prevention can offer an important component of an effective approach to reduce or eliminate the risk of violence in the workplace. Having the WVPP in written form is essential to ensuring components of the plan have been effectively implemented. Establishing policies for the WVPP ensures the reporting, recording, and monitoring of incidents. Employers would be required to notify all employees of the existence of the WVPP, how to report violent incidents, and whom to contact with questions via postings in areas accessible to all employees.

Paragraph (c)(2) identifies the specific elements that OSHA requires in the WVPP. Paragraph (c)(2)(i) specifies that the WVPP contain a copy of the workplace violence hazard assessment, including all identified high-risk areas and activities and a review of all incidents of workplace violence that have occurred in the establishment, service or site of care within the past three years (whether or not an injury occurred). The specific requirements for hazard assessments for
home healthcare and emergency medical services are described in additional detail in discussions of paragraph (e) Control Measures, Table E-1 for Home Healthcare and Field-Based Social Assistance Services--Workplace Assessment and Control Measures, or Table E-2 for Emergency Medical Services--Workplace Assessment and Control Measures, as applicable.

Paragraph (c)(2)(ii) would require the WVPP to include all standard operating procedures (SOPs) associated with the development and implementation of workplace violence control measures to address identified workplace violence hazards or risk factors, including written records of controls implemented (if applicable). More specific requirements for these control procedures for home healthcare and emergency medical services are described in additional detail in discussions of paragraph (e) – Control Measures, Table E-1: Home Healthcare and Field-Based Social Assistance Services, or Table E-2: Emergency Medical Services, as applicable.

Paragraphs (c)(2)(iii) and (iv) of this draft standard specify that the WVPP must include all SOPs associated with recording, reporting and/or investigating violent incidents as required in paragraph (g) - Violent Incident Investigation and Recordkeeping. These SOPs could include, for example: how employees will document and communicate information regarding conditions that may increase the potential for workplace violence incidents to other employees and between shifts and units; how an employee can report a violent incident, threat, or other workplace violence concern; how employees can communicate workplace violence concerns without fear of reprisal; how employee concerns will be investigated, and how employees will be informed of the results of the investigation and any corrective actions to be taken. Assuring personnel that an individual can report a potential workplace violence problem without fear of reprisal would remove barriers to identifying problematic and possibly dangerous situations as they arise in the workplace (further discussion on this is presented later in discussion of paragraph (g)- Violent Incident Investigation and Recordkeeping, and paragraph (i) Anti-Retaliation).

Paragraph (c)(2)(v) requires employers to develop procedures to communicate and coordinate their WVPP with other employers at the same worksite. This is a topic for which OSHA is particularly interested in engaging with SERs on how multi-employer worksites currently coordinate their workplace violence prevention and other safety and health efforts. OSHA is also interested in SERs’ perspectives on whether and how multi-employer duties and responsibilities should be specified in a rule.

The draft regulatory text requires communication and coordination between the host employer and any contractors, vendors, staffing agencies, and licensed independent practitioners with privileges. Host employers would be required to include a description of the procedures to protect other employers on the worksite from workplace violence, ensure that other employers on-site adhere to the host employer’s WVPP, and establish procedures to facilitate
communication. In turn, other employers on a multi-employer worksite would provide to the host employer a description of how their WVPP coordinates with that of the host employer. This collaborative effort could ensure that these requirements are fully-met in a way that is least burdensome to all employers and most protective of the safety and health of the workers.

Paragraph (c)(2)(vi)(A) and (B) outline requirements for employers to develop procedures for involving non-managerial employees and their representatives (if necessary) in developing and implementing the WVPP. This includes involvement with identifying, evaluating, and correcting workplace violence hazards. It also includes the design and implementation of training and reporting procedures. The WVPP would include the employer’s written procedures for providing training to all covered employees. This element emphasizes training on potential violence that these employees in specific units or operations are actually exposed to. This approach focuses on necessary information and minimizes wasted employee time. Further information on the subject of training is provided in the description of paragraph (f)-Training in this document.

Under paragraphs (c)(2)(vi)(C) and (D), employers would also be expected to involve non-managerial employees in the investigation of workplace violence incidents, as well as in the review of the WVPP. OSHA expects that employees involved in the investigation may include non-managerial employees as well as employees from security services, environmental services, occupational safety and health, human resources, medical staff, and social services, and/or others, as relevant.

Although management is responsible for controlling hazards, employees have a critical role to play in helping to identify and assess workplace hazards. Non-supervisory employees have knowledge and familiarity with the operation of the establishment, process activities and potential threats. Active involvement of all employees, particularly non-managerial workers, is necessary for an effective WVPP. OSHA believes that management leadership and employee participation are critical elements for an effective WVPP. The active involvement of employees can be critical in identifying, evaluating, and correcting workplace violence hazards, and in the design and implementation of training, reporting procedures, investigation of workplace violence incidents, and periodic review of the WVPP. Employees with different job functions and at various organizational levels should be included so that they bring a broad range of experience and skills to program design, implementation, and assessment.

Paragraph (c)(2)(vii) would require that the name and job title of the designated program administrator be included in the WVPP. The program administrator is the person(s) responsible for providing logistical oversight and coordinating and managing administrative and technical oversight of all elements of the WVPP. OSHA believes that there needs to be one individual named as the primary program administrator for the WVPP, along with the names and job titles of persons responsible for implementing the program. This individual may be an employee of the
establishment or contracted by the establishment to meet the obligations of the program. This
draft rule would require that, if the designated program administrator does not have the
knowledge, skills, or training necessary to implement and oversee the program effectively, then
they would be required to consult with appropriate personnel who have such knowledge, skills or
training to ensure that the WVPP is implemented and overseen effectively. OSHA envisions that
this individual would be responsible for ensuring that the plan is: written, implemented and
reviewed; provided to all employees who require training; and followed establishment-wide. The
WVPP would need to be promptly updated if there is a change in the designated program
administrator.

Under paragraph (c)(3), OSHA would require that covered employers reevaluate policies and
procedures on a regular basis to identify deficiencies and take corrective action. In the regulatory
text provided in this package, a team consisting of management, non-managerial employees, and
their employee representatives (if applicable) would review and update the WVPP at least
annually. Employers must also conduct subsequent area-specific hazard assessments in response
to any workplace violence occurrences in an area not previously identified as high-risk, physical
changes in the workplace that could increase the risk, or changes in clientele or services provided
that could increase the risk (this is explained in further detail in the explanation for paragraph
(d)(4) – Additional hazard assessments). The team would also evaluate records and information
pertaining to the implementation and effectiveness of the WVPP as part of the review.

Employers would be required to establish and maintain written records for each review and/or
update of the WVPP. OSHA anticipates the written review would include effectiveness of
training, incidents that have been reported, compliance with the plan, and a determination of
whether the written program has adequately addressed the roles, expectations and clear
procedures for all job duties. Management would share workplace violence prevention
evaluation reports with all workers. Any changes in the program would be discussed at regular
meetings of the established committee, with employee representatives or other employee groups
(if applicable), and shared with all employees. OSHA has included privacy provisions in the
draft regulatory text to ensure that any reports that are generated and audited as part of the
WVPP review would protect worker and patient confidentiality either by presenting only
aggregate data or by removing personal identifiers if individual data are used.

Paragraph (c)(4) of the draft rule would require employers to allow sufficient time for employees
to complete any required WVPP activities (e.g., training, reporting, incident reviews, etc.) at a
reasonable time and place. This requirement is intended to ensure employee involvement in all
aspects of the program. See paragraphs (f) - Training and (g) - Violent Incident Investigation and
Recordkeeping for further discussion.

Paragraph (c)(5) would require employers notify all employees within the entire establishment
(regardless of duties) about the existence and contents of the employer WVPP. The employer must also clearly communicate to all employees how to report workplace violence incidents and who to contact with questions. This notification is to be posted on-site in writing in conspicuous areas accessible to all employees, but OSHA realizes that employers may also wish to utilize other communication methods (newsletters, intranet system postings, etc.) to supplement these physical postings. A copy of the WVPP and the most recent workplace hazard assessment and effective procedures to mitigate hazards must be always made available and accessible to all staff. OSHA welcomes feedback on the draft WVPP requirements.

(d) Workplace Violence Hazard Assessment.

Paragraph (d) of the draft standard requires each employer to conduct a hazard assessment of risk factors throughout the establishment. These employer evaluations are intended to identify environmental and organizational risk factors that may occur throughout a fixed establishment site. This is done by gauging the likelihood of workplace violence incidents and determining the best way to remove or minimize the risk. There are several provisions required to accomplish this assessment.

As stated above in the discussion of the WVPP, a successful hazard assessment needs the commitment of management, involvement of employees, and tailoring to the types of services provided and the volume of patients/clients/residents and their visitors. A successful hazard assessment will identify risk factors that contribute to the likelihood of violence in the workplace. Many risk factors relate to patients, clients, and care delivery settings and include: working directly with people who have a history of violence, people who abuse drugs or alcohol, patients with a condition that causes confusion or disorientation, or distressed relatives; poorly lit corridors, rooms, parking lots, and other areas; lack of a means of emergency communication; and unrestricted movement of patients or clients and their visitors within facilities. The assessment would help inform decisions regarding the types of controls that would best meet the needs of each establishment and take into consideration the types of services provided, the size and layout of the physical buildings and surroundings, and other environmental and organizational characteristics.

Physical injury or threat of physical injury caused by the action of a patient or client, their family, or visitors may not be entirely eliminated for employees who must be physically close to patients/clients/residents, their family, or visitors when administering care. Factors associated with employees’ risk of workplace violence include the frequency and duration of close contact, characteristics of the physical environment where the interaction occurs, and organizational characteristics related to the policies, procedures, work-practices, and culture of safety in the organization. These types of characteristics, or risk factors, can be addressed by 1) the actions management takes to improve worker safety; 2) worker participation in safety planning; 3) the availability of appropriate protective equipment; 4) the influence of group norms regarding
acceptable safety practices; and 5) the organization’s socialization process for new personnel, all of which promotes a healthy organizational culture of safety.

OSHA’s regulatory approach for hazard assessments is to focus on desired, measurable outcomes, rather than relying on many prescriptive regulatory provisions. Each employer could tailor their assessment to the highly variable risk levels of the establishment’s patient/client/resident mix, the physical characteristics of the establishment, the volume of patients and clients, and characteristics of the surrounding community.

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

OSHA would require in paragraph (d)(1) that all covered employers conduct a workplace hazard assessment to facilitate prevention of patient, client, or visitor-initiated violence against employees. The workplace hazard assessment would apply to employers providing healthcare or social assistance services within an employer-operated fixed-establishment site of care. In this context, an establishment means the totality of the space operated by the employer or host employer. This may include a host employer that controls operations within several buildings or even a sprawling campus with multiple buildings, parking lots, or satellite sites. All covered employers who provide healthcare and social assistance services in fixed-establishment sites of care would conduct the workplace violence hazard assessment described here.

Employers would tailor the structure of their hazard assessment to many other factors including the manner in which care is organized and provided (modalities of care); whether the establishment is located in a rural or urban setting; federal, state and local laws; and other business practices. Under the draft regulation, employers would have the flexibility to determine the best approach to accomplish the overall hazard assessment. In addition, each hazard assessment could be tailored to specialized clinical services, the physical characteristics of the establishment, the number of patients and clients in the establishment, and characteristics of the surrounding community of the establishment. For example, smaller facilities with lower volumes of patients or clients might require a minimal level of infrastructure and effort to regulate the flow of people in and around the establishment in order to manage risk appropriately.
Conversely, the high volumes of patients or clients in large facilities may present a higher likelihood for employees to unknowingly be at risk for violent behavior given the amount of client and visitor movement in and around the establishment.

Paragraph (d)(1)(i) would require covered employers to provide an opportunity for employees to report workplace violence incidents, whether or not the incident resulted in an injury, that occurred in the establishment during the previous three years. Paragraph (d) requires employers to record any previously-unreported incidents, and to conduct a review of these reports. It is important for employers to fully engage employees in the hazard assessment process. Although management is responsible for controlling hazards, workers have a critical role to play in helping to identify and assess workplace hazards because of their knowledge and familiarity with the operation of the establishment, process activities, and potential threats.

In particular, workers who provide direct patient care have front-line experience, are very knowledgeable about the risks their patients present, and have familiarity with the operation of the establishment and their job tasks. These workers include, for example, clinicians, nurses, therapists, technologists, technicians, and nursing aides, patient observation aides, environmental services staff, etc. A hazard assessment would ideally be made by a team that includes senior management, risk management staff, supervisors, and both clinical and non-clinical workers. Representation of emergency response teams and/or security staff would also be helpful. Depending on the size and structure of the organization, the team may also include staff representing other operations of the establishment including environmental services, employee assistance, dietary services, security staff, occupational safety and health, risk management, human resources, and others.

Some employees, out of consideration of a patient’s mental health status at the time, may not report patient acts of violence against them to their supervisors, and regard patient outbursts as normal coping mechanisms. As has been reported by the GAO and in the literature employees often choose not to report an incident to the employer for various reasons, including: the perception that workplace violence is part of the job; lack of policies, procedures, and staff training; time consuming reporting procedures; lack of support or follow-up; fear that the employee would be blamed; or that patients are not accountable for their violent actions. (Findorff, et. al. 2005, Arnetz, et. al., 2015, Ex. 0006)

Employee perceptions of workplace violence incidents leading to underreporting can cloud the review of past incidents. Patterns of patients’ behavior and the effect of environmental and organizational risk factors may not be detected when incidents are not reported. The requirement in paragraph (d)(1)(i) gives the employees an opportunity to report all such incidents without the threat of harm or further retaliation from the patient, family, or visitors. The employee reporting element of paragraph (d)(1)(i) is intended to yield a more robust and effective hazard assessment
when the employer makes clear that reporting of workplace violence incidents is both expected and required.

Paragraph (d)(1)(ii) would require that employers record all previously-unreported workplace violence incidents in the establishment in the previous three years in order to best inform their hazard assessment. OSHA expects that these unrecorded incidents will typically be at the level where they did not meet the criteria for reporting to OSHA (e.g., there were not injuries that required hospitalization or missed work time) in order to provide the most accurate portrayal of workplace violence hazards possible. During an employer’s first hazard assessment, OSHA is contemplating that the employer would consider the collection of employees’ recollection of incidents, including threats, which occurred before the implementation date of a rule. Although details of an incident are frequently hard to recall precisely as time passes, OSHA expects that capturing information from as many former incidents as possible would be instrumental in identifying risk factors and planning interventions during the first hazard assessment.

Paragraph (d)(1)(iii) would additionally require employers and participants in the review process to examine all workplace violence incidents that occurred within the previous three years. These incidents could have been experienced by an employee or contractor, vendor, and/or licensed independent practitioner with privileges. The employer would evaluate, at a minimum, all data recorded in the violent incident log and incident investigations and data from all other available sources, including surveys of employees; OSHA 300 logs; Workers’ Compensation claims; insurance loss information; and other ward-specific incident logs. A review of incidents would focus on characteristics of the employee involved, the patients or clients committing the incidents, and the physical and social settings in which the events occurred.

Under paragraph (d)(1)(iv), employers would also be required to evaluate employee risk for workplace violence based upon the level and types of crime in the employer’s served community. For example, emergency departments (EDs), because they typically serve the community 24 hours a day and are generally accessible to the public, may expose employees throughout the establishment to the community at large. Criminal occurrences in the community at large can spill into the ED or other specialty services such as intensive care trauma units (Blando, et. al., 2012; Joint Commission, 2021a) Employees who work in facilities in or near high crime areas could be at risk as they enter and leave the healthcare establishment or while delivering care to patients/clients/residents residing in or near areas with increased levels of crime and/or specific types of crime. An assessment of the level and types of crime in the surrounding community would help determine appropriate and most effective types of controls.

OSHA expects that employers will access such information, free of charge, through the use of publicly accessible web-based resources such as the FBI Criminal Justice Information Services (CJIS) - Uniform Crime Reporting Program Crime Data Explorer resource to obtain data at the
county or city law enforcement agency level, or even more granular and individual community level data available from such resources as CityProtect, SpotCrime, or Lexis-Nexis Community Crime Map.

Paragraph (d)(1)(v) would then require employers to assess all areas of their establishment for the following risk factors:

(A) Employees with direct patient/client/resident care or contact duties working alone or in remote locations, or during night or early morning hours.

(B) Locations within the establishment without emergency communication, such as areas where alarm systems are not installed or operational, or where any obstacles and impediments to accessing alarm systems may exist. The lack of security systems, alarms, or devices can limit staff’s ability to seek assistance and limit appropriate response to situations where violent incidents are imminent or have occurred, increasing the likelihood or the severity of an incident.

Obstacles and impediments to accessing alarm systems or locations within the establishment where alarm systems are not installed or operational may present undue risk for workplace violence. All employers must ensure an escape route out of the area for all of its employees. Every escape route will be assessed to determine that the employee can move from the area of violence to a safe area, unimpeded by obstacles. Hallways should have a clear path to a safe area or to the outside of a building. Doorways, whether alarmed or not, should be unblocked and swing free to an open space in the building or to the outside.

(C) Ineffective communication mechanisms or practices regarding patient/client/resident status between shifts and between personnel. The employer would be required to evaluate whether the communication of patient/client/resident information is effectively handled. If ineffective communication mechanisms or practices regarding patient/client/resident status between shifts and between personnel are identified, new or updated policies or protocols will need to be developed and implemented. Information about a patient’s or client’s propensity for violent behavior can be obtained from care provider notes, notes from the transferring units within or external to the establishment, or emergency medical services staff who may have transported a patient to an emergency department. Inadequate communication between work shifts and between personnel among the various care units, clinics, and departments, may expose employees to undue risk of workplace violence incidents. In addition, inadequate communication about a patient’s or client’s propensity for violent behavior can increase risk for employees who are unaware of this propensity, and hinder appropriate changes in staffing, procedures, or duties. If employees know patients’/clients’ history of aggressive behavior, they may also be better able to recognize warning signs and intervene to avoid a violent incident.

In addition, paragraph (d)(1)(vi) would require employers to assess all high-risk service areas. In
these high-risk service areas, employers must also assess for additional risk factors. The levels of risk associated with these specific risk factors depend on unique environmental and organizational characteristics of each establishment. Host employers would evaluate their facilities and implement interventions with the intent of minimizing frequency and severity of workplace violence incidents associated with high-risk services. These risk factors can be identified during a walk-through inspection by an assessment team, especially if it is a large establishment, or by a single employee in a small establishment. The host employers operating large facilities usually provide many types of services where employees interact with patients and clients. Conversely, it might be appropriate that only one employee who is intimately familiar with the patient mix, building, and services of a small establishment such as a small residential behavioral health group home would be capable of performing a walk-through inspection to identify risk factors for workplace violence. The additional assessments for high-risk areas include:

(A) Poor illumination or areas with blocked or limited visibility. These areas pose a high-risk factor, limiting employees’ ability to detect and avoid potential threats of harm during their course of work. An area having poor illumination or limited visibility impedes the safety of employees performing work in these areas. Repositioning light fixtures, changing to LED bulbs, or installing motion sensors on lights to turn on when there is movement, and use of convex mirrors or video equipment in those areas are all examples of how better visibility can be accomplished.

(B) Employee staffing patterns that are inadequate to reduce workplace violence or to respond to workplace violence incidents. Employee staffing patterns vary by establishment, and depend on the acuity of the patients or clients served. OSHA considers inadequate staffing to be a risk factor in workplace violence because it can both agitate patients/clients/residents as well as prevent prompt response if a workplace violence incident occurs.

(C) Lack of physical barrier protection between employees and patients/visitors in areas such as admission, triage, and nursing stations. It may be necessary to provide physical barrier protection in some areas of an establishment. Patients, clients, and visitors to healthcare and social assistance settings may experience increased stress and agitation that increases the risk of violent behavior. Those employees working in an admissions office or a triage desk may encounter hostile patients/clients/residents. Having a clear partition between the employee and the patient/client/resident will provide a protective barrier, while not impeding the communication process.

(D) Lack of effective escape routes. Employees can be at risk when entering a resident’s room, an examination room, or other areas where a patient or client could easily maneuver to limit the opportunity for retreat, to alarm, or otherwise seek help.

To the extent feasible, rooms should have two exits. Doors may be outfitted with panels that can be kicked or popped out by responders in the case of barricaded doors.
(E) Entryways where unauthorized entrance may occur, such as doors designated for staff entrance or emergency exits. Unregulated and unmonitored patient, client, and visitor movement in and around the establishment via entrances/exits, halls, rooms, or stairwells, provides the opportunity for uncontrolled contact between employees and patients or clients, elevating the likelihood of workplace violence incidents. This provision would require that all entryways be assessed to determine if an unauthorized entrance could occur. Any doors that are designated for staff entrance or emergency exits should be assessed to ensure that only those with the authority to enter/exit can gain access and no other individual can enter/exit, possibly using an audible alarm.

(F) The presence of unsecured furnishings or other objects that could be used as weapons. Employers would be required to assess the furnishings provided (e.g., chairs, tables, wall hangings, curtain rods, blinds, clocks, pole-based medical equipment) in high-risk areas to determine if these objects could be weaponized. Any item that is not bolted down or connected together could be swung or thrown toward an employee by an aggravated individual if a situation escalates. OSHA would also require that the employer establish a system for promptly addressing the findings from the hazard assessment, and a plan to abate the hazards and risk factors in an immediate or timely manner. This plan includes a written schedule of when such actions are to be completed and communication of these actions to employees who may be affected by the identified risk factors. Paragraph (d)(2) would mandate that each employer establish and implement effective procedures to address the findings from the hazard assessments and maintain written records of these plans as they progress over time. OSHA believes that a written record is an essential component of communicating and managing risks within an organization. Written records document that an assessment was made, identify which job tasks or occupations might be affected, and account for the number of people who could be involved.

Employers would be required to maintain these written records that document the risk factors that were identified and addressed, that abatements were well reasoned and appropriate, and that any remaining risk was minimized. OSHA believes that requirements for written documentation help to track the progress of the worksite hazard controls, and is contemplating requiring hazard identification, evaluation, and correction records to be maintained by the employer for three years (as specified in paragraph (d)(1)(2)(x) and (h)(1)(ii)), or for as long as there is an unresolved hazard mitigation project pending or still in progress. A copy of the procedures to address the findings of hazard assessments fulfilling the requirements in this section would also become part of the written WVPP.

To implement these procedures, paragraph (d)(2)(i) would require that written records of the hazard assessment be maintained and include identification of any high-risk service areas.
Paragraph (d)(2)(ii) would require the identification of any specific hazards or risk factors found.

Under paragraph (d)(2)(iii), employers would be required to develop a plan to abate the identified hazards or risk factors in an immediate or timely manner during the interim of more permanent abatement.

Under paragraphs (d)(2)(iv) and (d)(2)(v), employers would also be required to document the date(s) that the assessment was performed, along with the names and titles of the individuals who participated in the evaluation.

Paragraph (d)(2)(vi) would require that the procedures to address the findings of the hazard assessments include the actions planned to address and prioritize the mitigation of the identified hazards or risk factors permanently.

Paragraph (d)(2)(vii) would require employers to communicate the status of planned or completed actions to all employees who may be affected by the identified hazards or risk factors.

Paragraph (d)(2)(viii) would require documentation of dates by which the employer’s planned mitigative actions are to be completed.

In paragraph (d)(2)(ix), OSHA has outlined draft requirements for employers to maintain written documentation of completed actions including the method(s) of control decided upon; the areas where controls were implemented; and specific date(s) of completion, including the names and titles of the individuals who authorized and managed implementation of controls.

Paragraph (d)(3) specifies that hazard assessments must take place annually. The annual review would include an assessment of the previous three years of workplace violence incidents. As part of this annual review, employers may need to designate an area to be high-risk based on the occurrence of a WPV incident. Likewise, an employer may determine that an area it previously deemed to be high-risk no longer is high-risk because there have been no incidents in the past three years. For example, if an incident occurred on a pediatric unit that was caused by a distressed or grieving parent three years ago, but no other incidents have been identified since, that unit could be re-classified as non-high-risk, provided that documentation exists to verify no new incidents. Areas OSHA defined as high-risk would still be deemed to be high-risk, even if no incidents occurred in those areas within the previous three years.

Similarly, if changes to the establishment’s business model (such as the acuity of patients treated or the types of services provided) reduce the workplace violence hazard in a particular area, those changes could be considered as part of the annual hazard assessment. For example, if an institutional reorganization results in the establishment no longer providing behavioral healthcare
or emergency room care, incidents in those areas would not be considered if the employer documents the lack of continuing need for that designation.

Paragraph (d)(4) requires employers to conduct additional area-specific hazard assessments in three situations. First, employers must conduct an additional area-specific hazard assessment when there has been a workplace violence incident in a service area or activity not previously identified as high-risk, in which case the assessment must be conducted within thirty days (see paragraph (g)(3)(ii)). Second, an additional area-specific assessment would be necessary when changes are made to the layout, design, or amenities of the physical workplace, such as installation or relocation of new nursing stations, reception desks, addition or renovation of patient counseling rooms, etc. OSHA believes that additional assessments under these circumstances would reduce the likelihood of a workplace violence incident stemming from the change.

Third, an additional hazard assessment is needed when a change in the clientele or services provided could increase the risk of workplace violence. For example, if there is an increase in the acuity (e.g., increased nursing care, higher-risk social services clients, etc.) of the patient or client population or new high-risk services are provided (e.g., substance abuse treatment center), these changes warrant an additional hazard assessment.

Paragraph (d)(5) of the draft regulatory text addresses employers’ hazard assessment responsibilities on a multi-employer worksite. This paragraph requires the host employer to conduct the hazard assessment and other employers to coordinate with the host employer to provide any information requested. OSHA believes that as the controlling employer of the establishment, the host employer is best-suited to take the lead on performing the hazard assessment. Each contractor, vendor and/or licensed independent practitioner with privileges, working at a worksite covered by the standard must coordinate with the host employer to comply with all provisions in paragraph (d).

This coordination would involve providing information on any incidents of workplace violence or communicating any hazardous risk factors that may lead to workplace violence. Host employers would also be required to share any information within their establishment related to the implementation of new or revised policies or procedures to address the findings from the hazard assessments with staffing agencies or other employers in the host employer’s worksite. OSHA is particularly interested in engaging with SERs to receive insight and feedback on how multiple employers who share a common work site currently coordinate their safety and health efforts in healthcare and social assistance industry sectors.

Paragraph (d)(6) specifies that paragraphs (d)(1)—(5) do not apply to home healthcare and field-based social assistance service employers or emergency medical services employers that place
employees in these settings. These employers would instead complete the hazard assessment elements in Table E-1: Home Healthcare and Field-Based Social Assistance Services, or Table E-2: Emergency Medical Services. The provisions in paragraph (d) are intended for fixed establishment-based employers with more control over the workplace.

Home healthcare and field-based social assistance services are unique in that they are provided outside of a fixed worksite, and are usually at the site of the patient’s or client’s residence. The variety of non-institutional environments within private residences, the types of services, and characteristics of communities, provide a unique challenge for employers in this field to provide a safe work environment for employees. Consequently, the requirements for workplace assessments for home healthcare and field-based social assistance services would be mandated in Table E-1: Home Healthcare and Field-Based Social Assistance Services – Workplace Hazard Assessments and Control Measures. Those provisions that apply for emergency medical services, which are performed in a variety of locations, can be found in Table E-2: Emergency Medical Services – Workplace Hazard Assessments and Control Measures.

(e) Control Measures.

Effective management of workplace violence in healthcare and social assistance requires the development of controls to reduce the risk of workplace violence by means of preventing and reducing the severity of these incidents. Once an employer’s hazard assessment is completed, control measures need to be considered and implemented for each identified risk factor. In rulemaking, OSHA considers the hierarchy of controls in determining the methods for controlling worker exposures to occupational hazards. Traditionally, the hierarchy of controls has been used to determine exactly how best to implement control solutions that are both feasible and effective. Generally, following this hierarchy of controls leads to the implementation of inherently safer systems to reduce the risk of illness or injury. The main concept behind the hierarchy of controls is that control measures can be grouped into categories of elimination, substitution, engineering, administrative/work practice controls, and finally, personal protective equipment (PPE). The hierarchy of controls is ordered in just that sequence, by most effective to least effective methods of control.

Elimination and substitution, which are generally the most effective control methods for reducing hazards, are concepts that tend to be less broadly applicable to controlling workplace violence in healthcare and social assistance settings. Therefore, OSHA has focused primarily on various engineering and administrative/work practice control strategies, and to a lesser extent, PPE, in this draft standard. The draft regulatory text requires employers to establish and implement workplace violence control measures based on the nature of the hazards to minimize the risk for workplace violence.

OSHA is considering multiple methods of control measures that would apply to all fixed
(establishment-based) worksites. OSHA has also identified multiple control measures for non-fixed worksites and worksites over which an employer may have less direct control (e.g. those of field-based emergency medical services or field-based healthcare or social assistance services).

**Engineering Controls**

The purpose of implementing an engineering control is ultimately to isolate or contain the workplace hazard from the worker. In healthcare facilities, engineering controls are physical changes to the workplace itself—usually an aspect of the built space or a device that removes or reduces a hazard, or creates a barrier between an employee and the hazard. Engineering control strategies could include, for example:

- Access controls to employee-occupied areas;
- Enclosed workstations with shatter-resistant glass;
- Deep service counters or other means to physically separate patients/clients/residents and their visitors from employees;
- Separate or isolation rooms or treatment areas for patients with a history of violence;
- Locking mechanisms for doors;
- Removing access to or securing items that could be used as weapons;
- Furniture affixed to the floor;
- Closed-circuit video monitoring and recording;
- Metal detectors at entrance points (installed or handheld);
- Other means of assuring visibility such as mirrors and improved illumination;
- Personal alarm devices; or
- Other engineering controls.

Engineering controls are only reliable so long as the controls are designed, used, and maintained properly. Without regular check and routine maintenance, the effectiveness of engineering controls become diminished. For example, video surveillance systems can be an effective tool for workplace violence prevention but if the equipment is not maintained, it can degrade with time, which may go unnoticed until it is no longer useful. Additionally, physical barriers engineered to protect workers are only effective if the physical integrity is assessed and maintained.

Where it is appropriate, several engineering control measures together can serve to prevent or minimize employee workplace violence incidents. For example, convex mirrors can be positioned above walkway intersections in conjunction with increased illumination to reduce the risk of entering a blind spot. Engineering controls for workplace violence prevention are also tangible solutions that can prevent a person who could be attempting to harm others or introduce a dangerous object from entering a work site.

**Administrative and Work-Practice Controls**
Administrative and work-practice controls are also important ways for employers to protect employees from workplace violence hazards. Administrative and work-practice controls are changes to the way staff perform jobs or tasks, both to reduce the likelihood of violent incidents and to better protect staff, patients, and visitors should a violent incident occur. Examples of work practice controls include maintaining sufficient staff for the hazard, as well as providing training on de-escalation techniques and how to respond to workplace violence. As with engineering controls, the practices chosen to abate workplace violence by means of administrative or work practice controls should be appropriate to the type of site and responsive to risk factors identified during the hazard assessment described in paragraph (d).

For example, establishing a system of communication—such as chart tags, log books or verbal census reports—can identify patients and clients with a history of violence and identify triggers and the best responses and means of de-escalation. OSHA is considering provisions that would require employers to ensure that their workers know and follow procedures for recording and communicating updates to patients’ and clients’ behaviors.

Administrative and work practice controls should evolve along with changes in the workplace. Once administrative and work practice controls are implemented, these controls would be evaluated at least annually, in conjunction with the annual hazard assessment described in paragraph (d), to ensure effectiveness. These annual reviews will allow for regular upgrades or modifications to administrative/work practice controls, if necessary.

Some additional examples of administrative controls include: developing standard operating procedures for the control of and response to a workplace violence incident and determining the behavioral history of new or transferred patients or clients to learn about any past violent or assaultive behaviors. Employers should also have procedures for summoning help during a workplace violence incident and procedures for staff designated to respond to a workplace violence incident.

**Personal Protective Equipment (PPE)**

Finally, employers may provide PPE where appropriate, and where engineering and/or administrative work practice controls alone are not fully sufficient to abate a given hazard. In the case of WPV, examples of appropriate PPE could include eye protection, and splash guards. In extreme cases within some behavioral health or psychiatric settings this could include the use of padded convex shields or scratch/bite resistant Kevlar sleeves, etc. These types of PPE controls are occasionally needed in specialized settings where the potential for violence is extremely high.

**Controls Contemplated for All Covered Workplaces**
OSHA solicits feedback on the controls identified in the draft regulatory text. As noted in paragraph (e)(6), the provisions in paragraph (e) would not apply to home healthcare and field-based social assistance service employers or emergency medical services employers. These employers would instead implement the control measures in Table E-1: Home Healthcare and Field-Based Social Assistance Services, or Table E-2: Emergency Medical Services. This is because the provisions in paragraph (e) are intended for establishment-based employers that maintain more primary control over their operations within their facilities, and employers in home healthcare and field-based social assistance service, or emergency medical services may operate with less direct control of the working environment. For all other settings, OSHA is considering a series of general engineering, administrative, and work-practice control measure requirements, as well as requirements for PPE, that would be applicable to all covered employers. Paragraph (e)(1) specifies that all covered employers would be required to implement certain control measures, including:

- Effective alarm systems;
- Workplace Violence Incident response procedures; and
- Policies for communicating patient/client/resident specific risk factors.

**Effective Alarm System**

Paragraph (e)(1)(i) requires employers to install, implement, and maintain an effective alarm system for use by employees with direct patient care/direct patient contact duties. Under the draft regulatory text, “alarm” means a mechanical or electronic device by which employees can summon assistance to respond to an actual or potential workplace violence emergency.

Employees with direct patient care/direct patient contact duties need to be able to signal for help whenever and wherever they need it. Alarms would be located in unobstructed locations that are easily accessible to employees. Acceptable alarms include stationary systems like wall-or desk-mounted panic alarm buttons. Some alarm systems provide a silent call signal, while others provide an audible call signal.

OSHA anticipates that most health care facilities already have some form of emergency communication system, such as a wall-mounted alarm or a building-wide public address (PA) system. Many establishments have implemented mass notification systems or have taken advantage of personal safety alarm devices, or smartphone, tablet, or computer-based applications to accelerate emergency responses when a workplace violence incident occurs. OSHA recognizes that many types of alarm systems can be effective and systems may vary depending on setting. For example, a small unit without regular workplace incidents may determine a wall-mounted alarm button is effective, while a setting with more frequent workplace violence incidents may provide employees with personal emergency devices such as panic buttons.
Workplace Violence Incident Response Procedures

The objective when implementing an alarm system is for appropriately trained persons to respond immediately to an employee’s call for assistance. Paragraph (e)(1)(ii) would require employers to establish and implement effective workplace violence incident response procedures. Appropriately trained employees must receive the signal for help in order to be able to provide a prompt response.

OSHA expects that any effective workplace violence incident response procedures would include standard operating procedures for a variety of incident response scenarios that might commonly occur at any fixed establishment. For example, paragraph (e)(1)(ii)(A) would require employers to establish and implement standard operating procedures for employees with direct patient care/client care or direct patient/client/resident contact to summon help during a workplace violence incident.

Paragraph (e)(1)(ii)(B) would require employers to adopt standard operating procedures for receiving patients/clients/residents who are actively exhibiting violent behavior, including those escorted by law enforcement officers. These could be individuals with mental health issues who require assistance because they may harm themselves or others. For example, this may be the case when an establishment is receiving individuals who are under the influence of substances, may have been involved in a violent altercation prior to arrival at the establishment, or are from a nearby correctional facility and may have histories of violence. These situations require that, where applicable, safety measures be taken to protect the health and safety of workers while still accounting for the needs of the patient/client/resident. For example, patients/clients/residents being escorted by law enforcement may need to be treated and/or tested in separate areas. Paragraph (e)(1)(ii)(C) would require employers to adopt standard operating procedures for staff designated to respond to workplace violence incidents. Many large healthcare settings may already have emergency response teams with designated members to respond to a variety of situations. At a minimum, workplaces would need to ensure that there is staff available to respond to a workplace violence incident. Some employers may determine it is appropriate to maintain a workplace violence incident response team.

Employees designated to respond to workplace violence incidents will receive advanced levels of training, and response team members may not have other assignments that would prevent them from responding immediately to an alarm to assist other staff. Team members may include clinical patient care/contact staff, a house manager or charge nurse, and/or security. Standard operating procedures would include how to ensure a prompt and coordinated response, as well as any other requirements, such as specialized training or evaluation.

Paragraph (e)(1)(ii)(D) would require that, if an employer uses restraint methods on patients, it
develops standard operating procedures for use of restraints in a manner appropriate to protect employees, particularly for high-risk services. It is the employer’s responsibility to ensure that to the extent it relies on restraints for incident response, any restraints used are effective and can be implemented in a way that minimizes risk to employees. Employers who use restraints must develop policies and procedures about when and how to use restraints or isolation, and this information must be provided to employees providing direct patient or client care or others responding to an employee’s call for emergency help.

OSHA understands that there are a number of existing federal, state, and local laws on restraint methods designed to protect patients, and OSHA does not intend this standard to interfere with any of those laws. OSHA also understands that the use of restraints are contraindicated in many healthcare and social service settings. OSHA is also aware of research indicating that the use of restraints can be significantly counterproductive to the effective treatment of certain patients. (NABH, 2021) As such, this draft standard does not require the use of restraints. However, OSHA understands that as part of the incident response, isolation or chemical/physical restraints may be an appropriate means to stop or minimize the severity of outcomes due to a patient or client exhibiting violent or disruptive behavior. Whereas OSHA does not intend that these techniques be required to be used by employers, these measures may be utilized in some settings.

Paragraph (e)(1)(ii)(E) would require employers to adopt standard operating procedures to respond to mass casualty threats, such as active shooters. An increasing number of healthcare facilities have begun to incorporate mass casualty scenario planning into their emergency response and workplace violence prevention programs. Active shooter response could include:

- When and how to involve local law enforcement;
- Development of a communication plan;
- Establishment lockdown and evacuation protocols;
- Training and drilling requirements; and
- Planning for post-event activities (e.g., evaluations, de-briefs, counseling).

Incidents of workplace violence may rise to a level that necessitates law enforcement involvement. For that reason, OSHA has included a provision in paragraph (e)(1)(ii)(F) that would require employers to adopt standard operating procedures for obtaining assistance from the appropriate law enforcement agency during all work shifts. These procedures may include establishing a central emergency coordination system (e.g., security desk, charge nurse’s station, etc.) for obtaining assistance from law enforcement agencies. The procedures may also identify who the appropriate law enforcement contacts would be and detail and how information is to be reported to external law enforcement agencies.
Communication of Patient/Client/Resident-Specific Risk Factors

Paragraph (e)(1)(iii) requires policies and procedures to communicate patient/client/resident-specific risk factors. This would include instructions for handing off care of patients or clients between employees during shift changes, transferring patients or clients between service units, and other transport. It is especially important to communicate to all relevant employees pertinent information about patients or clients with a history of violent behavior. Employers must also identify and communicate any event triggers for patients/clients/residents, identify the type of violence (including severity, pattern, and intended purpose), and use this information to develop plans to prevent future violence. Covered employers must develop their own system (e.g., chart tags, log books, patient/client/resident handoff tool, census reports) to communicate patient/client/resident-specific risk factors to all employees who may encounter the patient or client.

In many covered settings, it may already be a common practice to engage in patient-management huddles, which could include a discussion of workplace violence and patient or client specific risk factors. OSHA believes it is important to standardize a protocol to ensure that all of the pertinent information is captured and communicated to all appropriate employees, which can help employees take adequate steps to anticipate or prevent workplace violence incidents before they occur. Practical checklists can be developed to collect general information on patient or clients that have exhibited, or are a potential risk for, violent or disruptive behavior. Such information may already regularly be obtained at admissions or through an initial consultation in the case of social assistance or home healthcare.

Paragraph (e)(1)(iii)(A) would require covered employers to establish and implement policies and procedures for employees to document and communicate a patient or client's prior history of violence, to the extent that such history is known to the employer or can be determined by records within the employer’s possession. OSHA believes that there is some variability with respect to the amount and level of detail that employers have access to in a patient or client’s electronic health records. Additionally, some but not all employers, particularly those in emergency departments within larger urban hospitals, may have access to law enforcement databases. Only history that is known to the employer needs to be communicated; OSHA does not expect employers to conduct an in-depth background check of anyone who presents for treatment.

Paragraph (e)(1)(iii)(B) would require covered employers to establish and implement policies and procedures for employees to document and communicate any conditions that may cause the patient/client/resident to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively. For example, diagnoses of mental or behavioral illness would be informative, as would any recent changes in medication or treatment that had been previously effective in controlling aggressive behavior (e.g., the employer knows that the
patient recently stopped taking medication that had been used to control anger and aggression. Information about patient alcohol or substance abuse or withdrawal symptoms would also be helpful to employees who will likely have contact.

Paragraph (e)(1)(iii)(C) would require covered employers to establish and implement policies and procedures for employees to document and communicate any recent disruptive or threatening behavior displayed by a patient/client/resident. This refers to the maintenance and communication of these behaviors during the time the patient or client has spent with the care provider.

Paragraph (e)(1)(iii)(D) would require covered employers to establish and implement policies and procedures for effective communication via flagging and the use of visible cues of a patient or client’s history or potential for violence on patient charts or client case history for all relevant staff. OSHA believes that many healthcare and social assistance employers use computerized systems (e.g., Epic) that allow for service providers to enter patient/client/resident data associated with propensity for violent behaviors that will pop up as an electronic flag in the form of a banner, symbol, or abbreviation on the screens of subsequent healthcare providers each time that patient’s file is opened. Additionally, simple stickers of certain colors, shapes, or icons may be placed on patient-assignment boards, patient room doors, above a patient’s bed, or on their mobility aids to serve as effective safety cues – particularly for members of the care team who may not have access to patient medical records (e.g., housekeeping, maintenance, dietary staff, etc.)

In many covered workplaces, the practice of flagging patient charts or case histories with a patient’s history or potential for violence may already be a standardized practice. However, it is critical that everyone who interacts with a potentially aggressive or violent patient is aware of that potential. Unlike emergency response protocols that notify workers of violent situations actively in progress, the practice of flagging patient records draws attention to the potential for violence. It involves exchanges of information that consist of visual and/or electronic cues that are easily recognizable. By taking this kind of proactive approach to managing violent or aggressive behaviors, employers can reduce the risk of harm to workers. OSHA seeks feedback on the types of visual cues currently used in the healthcare and social assistance sectors and whether SERs have found such cues to be helpful in reducing the risk of workplace violence.

Paragraph (e)(1)(iii)(E) would require employers providing direct care to establish and implement policies and procedures to document and communicate a patient or client’s treatment and medications, including the type and dosage, as is known to the establishment and employees.

Under paragraph (e)(1)(iv), employers would be required to establish and implement policies and procedures for effective communication of a patient/client/resident’s history or potential for
violence to all subsequent external healthcare employers that a patient may be referred to. Much in the way that paragraph (e)(1)(iii) would establish requirements for employers to communicate information about a patient or client’s prior history of violent, disruptive, or threatening incidents. OSHA is considering requiring such information to also be provided to that patient/client/resident’s subsequent healthcare providers. One potential approach would be to implement a flagging alert program to communicate violence-related risks to healthcare teams. As described earlier, OSHA believes that many healthcare and social assistance employers use computerized systems that allow for service providers to enter patient/client/resident data associated with propensity for violent behaviors that will pop up as an electronic flag for subsequent providers. OSHA believes this type of communication will help subsequent healthcare providers better prepare and anticipate the workplace violence risk and take proactive steps to address it.

Again, only a patient/client/resident’s known history is required to be communicated and employers are not expected to conduct an in-depth background check of anyone who presents for treatment. Furthermore, the communication of sensitive information must, of course, follow federal, state, and local laws.

Controls in High-Risk Service Areas of Covered Fixed Facilities

As noted above, paragraph (b) defines high-risk service area as a setting “where there is an elevated risk of workplace violence incidents.” Such services and settings would include “emergency rooms/emergency admissions/ triage areas, psychiatric care, behavioral health care, substance abuse treatment, home healthcare, social assistance, emergency medical services, and other areas deemed to be of high-risk for violence by the employer.” In general, any service area wherein a workplace violence incident has been recorded in the previous three years is to be considered high-risk unless there is a written determination of why this designation is not appropriate. An isolated incident and one that is not likely to happen again may not be grounds to designate that unit a high-risk area, so an employer would need to document that such a designation is inappropriate in this case. For example, an isolated domestic dispute in a maternity ward that customarily does not see such instances may not alone warrant designation as a high-risk service area. These high-risk areas would require additional engineering controls and work-practice controls be put into place to ensure the safety of employees.

OSHA recognizes that each healthcare and social service establishment is unique and thus workplace hazard assessments will identify different hazards. OSHA expects that controls selected would be site-specific and appropriate to the specific setting. For example, closed circuit videos and shatterproof glass may be appropriate for one particular hospital or other setting with a history of workplace violence incidents, but perhaps less-so for some other community care establishment that has never experienced such an episode. Due to the complexity of workplace violence in healthcare and social assistance, OSHA expects that employers would adjust and
tailor all control measures for each establishment or service area based on the specific risk factors that are identified during hazard assessments. (e.g., size of the building, patient case-mix, type of services provided, prevalence/type of crime in the surrounding community).

*Engineering Controls in High-Risk Service Areas*

In paragraph (e)(2) OSHA outlines draft requirements for employers to implement additional engineering control measures to prevent or reduce the risk of workplace violence in high-risk service areas. Paragraph (e)(2)(i) would require that in high-risk areas, employers must ensure that employees have a clear line of sight in public areas of the establishment, including waiting rooms and hallways, so that employees can observe all activities in areas where members of the public are moving through care or service areas from their work stations without impediment by room design, furniture, and/or other objects. This includes ensuring that no sight barriers exist, sufficient illumination exists, surveillance systems or other sight aids are installed such as convex mirrors in ceiling corners, and other effective means. The purpose of this requirement is to ensure employees are able to observe what is happening around them.

Paragraph (e)(2)(ii) would require that employers ensure that employees have unobstructed access to alarms and exit doors as a means to escape violent incidents in high-risk areas. Employees must have unobstructed access to exit doors and alarms in all high-risk areas in order ensure the ability to escape violent incidents. Additional modifications to the physical layout of high-risk service areas be could be implemented to accommodate access to exit doors where appropriate.

For example, if a hazard assessment indicates that nurses are at risk when working with a bedside intravenous therapy apparatus because they must position themselves with the bed blocking the alarm button and the door, then the resulting control could then be to modify the physical layout of a patient’s room. The bed and medical equipment could be moved in order to ensure that alarm systems are not blocked. Administrative controls that may also mitigate this hazard could be to train employees to interact with patients from the side of the bed next to the door and alarm to the extent that it is possible.

Paragraph (e)(2)(iii) would require employers to remove, fasten, or secure furnishings and other objects that may be used as improvised weapons in high-risk areas where direct patient/client/resident contact/care activities are performed. OSHA is aware of many instances where objects were used as weapons to attack healthcare and social assistance workers.

Paragraph (e)(2)(iv) would require that employers install protective barriers between employees and patients or visitors in areas such as admission, triage, and nursing stations in high-risk areas. OSHA is aware of numerous incidents where patients were able to access the nurses’ station and attack employees and believes that this is an important and feasible control to prevent such
attacks. Enclosed nursing stations, physical barriers such as deep service counters, or electronic access controls and locks would be appropriate and the employer’s assessment could indicate which is most appropriate for the facility.

Paragraph (e)(2)(v) provides that an employer need not implement one of these engineering controls to address the hazard in a particular area if the employer has demonstrated in writing as part of its hazard assessment that the control is not appropriate or feasible for that area.

Work-Practice Controls in High-Risk Service Areas

Paragraph (e)(3) would require employers to implement additional work-practice controls in high-risk service areas. Paragraph (e)(3)(i) would require employers to install, implement, and maintain the use of personal panic alarms or other effective means of automated personal emergency communication for employees with direct patient care/direct patient contact duties in high-risk service areas. In high-risk areas, employees would be provided with personal safety communication devices. These devices can be worn and be used to send an alarm signal in the event of a workplace violence incident or when an employee needs assistance in an emergency. These devices include technologies that can send “safe check-in” messages as well as panic alarms. Some devices provide two-way communication ability. OSHA envisions that training on use of these devices (including training on the limitations of these devices) would be a component of this work-practice control.

Paragraph (e)(3)(ii) would require employers to create a security policy to address the movement of authorized and unauthorized persons and weapons into and throughout the establishment. This may involve developing policies on the use of electronic keycards or access codes used to regulate access to certain areas or the use of metal detectors to prevent weapons from being brought into the building and training employees on using metal detectors and removing weapons.

Paragraph (e)(3)(iii) would require employers to maintain staff designated to immediately respond to workplace violence incidents in high-risk service areas. OSHA is aware of numerous workplace violence incidents that occurred because there were not staff available to respond to the incident. OSHA believes that having staff designated to respond to workplace violence incidents in high-risk areas will reduce both the frequency and the severity of such incidents. Under paragraph (e)(1)(ii)(C), employers must develop establishment-wide standard operating procedures for the staff designated to respond to workplace violence incidents; paragraph (e)(3)(iii) requires maintaining sufficient staff that are designated to respond to workplace violence incidents in high-risk service areas.

Paragraph (e)(3)(iv) would require employers to ensure that staffing patterns are sufficient to address the workplace violence hazard. OSHA would require that staffing patterns account for
changes, including: intensity of patients’ or clients’ needs; the number of admissions, discharges and transfers during a shift; level of experience of nursing staff; layout of the unit; and availability of resources (ancillary staff, technology, etc.). OSHA envisions that the employer would maintain staff at levels appropriate to ensure that patient acuity needs are met, that there are enough staff for all one-to-one orders, for the buddy system to be used for certain patients, etc.

Additionally, paragraph (e)(3)(v) provides that an employer would not need to implement one of these work practice controls to address a hazard if it demonstrates in writing that the control is not appropriate or feasible for that area.

**Personal Protective Equipment (PPE)**

Paragraph (e)(4) contains a draft requirement that the employer must provide appropriate PPE including bite-resistant sleeves, protective facewear, etc. Appropriate PPE should be selected based primarily on the hazards identified during the assessment. In extreme cases within some behavioral health or psychiatric settings this could include the use of padded convex shields. Such PPE controls are occasionally needed in specialized settings where the potential for violence is extremely high. Other examples of PPE would be the use of gowns, gloves and face masks and shields to protect employees from saliva or other body fluid exposure that can occur when a patient is physically violent. The employer would be required to provide all such PPE at no cost to the employee (see paragraph (e)(4) and § 1910.132(h)(1)).

**Multi-Employer Worksites**

Paragraph (e)(5) provides that it is the responsibility of the host employer to establish and implement all workplace violence control measures. OSHA believes that the host employer maintains the highest level of control over the work environment and seeks feedback from SERs on whether this is appropriate.

**Tables E-1 and E-2: Workplace Assessment and Control Measures for Home Healthcare and Field-Based Social Assistance and Emergency Medical Services**

OSHA understands that employers who provide services within patients’ and clients’ private residences, or in other field-based settings, as with home healthcare, home or field-based social assistance, and emergency medical services may have very little control over their employees’ working environments.

OSHA believes that patients and clients receiving home healthcare are commonly asked to provide a safe environment for the employee as a formal condition of receiving healthcare, and perhaps to a lesser-degree, social assistance services in the home or other site of care. Patients and clients (and their families or other legally-designated decision-makers) are usually required
to formally agree to these conditions prior to receiving care. OSHA also believes that employers and employees in home healthcare already assess the residence for obvious risks before providing services but may not be in a position to make a thorough assessment to the same degree as those host employers who assess fixed healthcare facilities.

Social service workers employed by various government or private employers also visit clients at their homes, but also may have clients who reside within covered institutional settings, such as residential care facilities or residential behavioral health facilities. Due to the nature of social services, these employers may not always have the same formal conditions of providing services set out with clients as may be the case with home healthcare, and clients may not always necessarily be expecting or welcoming the visit.

Emergency medical service employees’ workplaces are highly variable and quite unpredictable with respect to environmental and organizational risks while providing medical services in the community at large. These services are often performed in private residences or public settings where most engineering controls are not possible or appropriate. These employees frequently face emergency situations and provide direct patient care in unfamiliar and highly variable settings. EMS employees providing this care often have no background information regarding persons needing their help. These employees make assessments and decisions quickly based on the immediate circumstances.

In the draft regulatory text, OSHA has provided Table E-1 titled “Home Healthcare and Field-Based Social Assistance Services – Workplace Assessment and Control Measures” (“Table E-1”). This table provides draft assessment and control requirements for employers within the home healthcare and field-based social assistance sectors. OSHA understands that home healthcare and field-based social assistance services are relatively unique in that these services are provided outside of an establishment and instead occur within a private residence where the physical environment is largely outside of the control of the employer. As such, hazard assessments and certain engineering controls may not always be feasible. Paragraphs (d)(1)—(5) and (e)(1)—(5) therefore would not apply in these workplaces.

OSHA believes that many employers in home healthcare, particularly those that receive CMS funding, already conduct an initial assessment of the residence where the care would be rendered consistent with the requirements of CMS OASIS Start of Care Assessments and other OASIS-based assessments triggered by events during the course of care. While this assessment may not be conducted in the same manner as within institutional settings, OSHA believes that such assessments are often routinely conducted as part of the service agreement between the healthcare provider and the client or patient. OSHA believes that the requirements in this draft regulatory text could be incorporated into that process. In each row (labeled (i) through (viii)) of Table E-1 there is both an assessment and control component, as indicated in the two columns
“Assessment” and “Control Methods” of each row. The assessment would be performed annually.

Table E-1 row (i) would require employers to review all workplace violence incidents within the previous three years. Row (i) would also require employers to provide an opportunity for employees to report previously unreported incidents and threats of physical harm, regardless of whether an employee sustained an injury. Row (i) would also require employers to conduct an evaluation of any work practice controls or personal protective equipment that may be implemented to minimize workplace violence hazards.

Once the incident record review is conducted, employers would implement control measures tailored to address the specific risks that have been identified. These measures include:

- Standard operating procedures for incident response;
- Standard operating procedures for obtaining assistance from the appropriate law enforcement agency;
- Policies and procedures for employees to document and communicate patient or client-specific risk factors to other employees, such as during handoffs between shifts; and
- Provision of PPE as appropriate.

Another risk factor to be assessed and controlled is how employees are able to communicate while working alone. Table E-1 row (ii) would require that as part of the assessment, the employer assess the adequacy of two-way personal emergency communications devices that can be used by employees to summon aid when working alone with patients/clients/residents. Following this assessment, row (ii) would require the employer to provide all employees with working personal emergency communications devices (e.g., cell phones equipped with emergency applications, two-way radios, wearable safety communication devices, etc.) that can be used by employees to summon aid. There are a number of devices and systems that can be implemented for communication with employees providing care in a residence. Cell phone apps and two-way radios are examples of some communication devices that can be used to summon aid. Mobile safety devices that accompany employees into the field can have communication software, and can be GPS tracked and outfitted with additional security applications. Employers who provide services across large service areas would need to assess which types of communication devices would ensure adequate coverage for its employees. OSHA is interested to hear from SERs about their experiences with or any limitations with use of such applications.

Table E-1 row (iii) would require an employer to assess the level and types of crime in the community where services are being provided. Following this assessment, row (iii) would require the employer to communicate this information related to the potential for violence in the surrounding community to each employee prior to the employee’s first visit. As mentioned earlier, OSHA believes that employers may readily access such information, free of charge,
through the use of resources such as the FBI Criminal Justice Information Services (CJIS) - Uniform Crime Reporting Program Crime Data Explorer resource to obtain data at the county or city law enforcement agency level, or even more granular and individual community level data available from such resources as CityProtect, SpotCrime, or Lexis-Nexis Community Crime Map.

Table E-1 row (iv) would require the employer to assess the efficacy of its procedures for collecting information concerning patients'/clients’ history of violence and the history of violence of anyone else in the household, and the employer’s procedures to provide that information to employees prior to the first visit. OSHA envisions that employers would establish standard operating procedures for obtaining and communicating to employees any information about a patient/client/resident’s history of violence, or the violent history of anyone in the household prior to the employee’s first visit. OSHA is aware of a number of workplace violence incidents involving home healthcare or social assistance services where employees were not apprised of the propensity for violence or the criminal history of patients/clients/residents or other members of the household wherein services were provided and were attacked.

As part of the assessment, OSHA expects that the employer would gather relevant information regarding violence from any available patient/client/resident medical records or additional sources of information in the employer’s possession. The employer would be required to document this information in the patient/client/resident’s chart and update the employee if there is any change in status.

It is important for employers to establish a clear, written policy about providing services in the presence of uncooperative, disruptive, and/or aggressive individuals. Table E-1 row (v) would require employers to assess whether a clear written safety policy exists to indicate the parameters for an employee to provide services in the presence of potentially violent patients/clients/residents or others. Employers would be required to evaluate whether the policy indicates parameters for when to continue the care visit, summon immediate assistance, or discontinue the visit. In response to this assessment, Table E-1 row (v) would require that in response to this assessment, the employer establish clear, written policies for what employees should do if they feel unsafe, e.g., due to aggressive patients/clients/residents or others in the household. Policies must include when an employee should call for assistance or terminate the visit.

Table E-1 row (vi) of OSHA’s draft regulatory text contains provisions for the employer to maintain and evaluate written records of the review of workplace violence incidents included in the assessment. Table E-1 row (vi) would also require the employer to create and maintain written records of workplace violence control measures implemented. Written documentation of the controls implemented would include:
(a) The methods of control decided upon;
(b) Area(s) where controls were implemented;
(c) Date(s) by which the controls will be implemented;
(d) Date(s) that the controls were implemented; and
(e) The names and titles of the individuals who authorized implementation of controls.

Table E-1 row (vii) provides that each covered employer would be required to review all incidents of workplace violence annually. Additionally, Table E-1 row (vii) contains a requirement that based on the review of incidents, covered employers must establish and implement additional workplace violence control measures to correct workplace violence hazards.

Finally, in Table E-1 row (viii), OSHA indicates that an employer would not be required to implement one of these workplace violence control measures to address the hazard in a particular area where the employer has demonstrated in writing as part of its review of workplace violence incidents that it is not appropriate or feasible.

OSHA clarifies here that under Table E-1, home healthcare and field-based social assistance services employers would not be required to perform reassessments after each workplace violence incident, as would be required for fixed establishment-based employers covered in paragraph (d). Instead, employers in home healthcare and field-based social assistance would need only to fulfill the requirements in paragraph (g) – Violent Incident Investigations and Recordkeeping with regard to documentation of significant contributing factors, recommendations, and corrective measures taken for each investigation -- which in turn would inform these employers’ annual review of incidents required under Table E-1 row (i).

**Worksite Assessment and Control Measures for Emergency Medical Services**

The draft regulatory text also includes Table E-2 “Emergency Medical Services –Workplace Assessment and Control Measures”. EMS employees face many types of hazards, including workplace violence. This table provides the draft assessment and control methods for employers within emergency medical services. Emergency medical services are also somewhat unique in this context, given that that they are provided in a highly dynamic work environment and employees may be working at many different sites throughout the shift. These services range from simple transportation of patients to and from medical care facilities to complex rescue and life support procedures.

EMS employees may not have much time to manipulate/stabilize the environment/situation or assess the patient or others present at the site of the emergency to mitigate the risk of workplace violence. Furthermore, time is of the essence for many patients/clients/residents of emergency medical services care. OSHA believes that employers providing emergency medical services already conduct a brief initial assessment to identify the potential for workplace violence during
each emergency response incident. Therefore, OSHA did not include a requirement for employers to perform a site-specific hazard assessment and to implement specific controls for employees at each site. In each row (labeled (i) through (v)) of Table E-2 “Emergency Medical Services – Workplace Assessment and Control Measures” there is both an assessment and control component, as indicated in the two columns “Assessment” and “Control Methods” of each row. The assessment would be performed annually.

The principal differences between Table E-2 for Emergency Medical Services, and Table E-1 for Home Healthcare and Field-Based Social Assistance is that OSHA has not included requirements in Table E-2 for employers in Emergency Medical Services to establish and implement procedures for obtaining and communicating to employees any information concerning a history of violence by the patient/client/resident or anyone else in the household prior to an employee’s first visit. OSHA does not believe that such provisions would be feasible for emergency medical services employers to implement, but would be interested to hear from SERs about their views on this exclusion in the draft regulatory text.

OSHA has also not included a requirement for employers to establish clear, written policies for what employees should do if they feel unsafe, e.g., due to aggressive patients/clients/residents or others in the household. Policies must include when an employee should call for assistance or terminate the visit. OSHA believes that many EMS providers already maintain a very close relationship with law enforcement agencies and frequently share separate duties at the same site. OSHA believes that when EMS providers feel unsafe, it is already customary for these workers to wait for police assistance to secure the scene prior to administering care. However, OSHA would also be interested to hear from SERs about their views on this exclusion in the draft regulatory text.

OSHA clarifies here that in Table E-2, emergency medical services employers would not be required to perform reassessments after each workplace violence incident, as would be required for facility-based employers covered in paragraph (d). Instead, emergency medical services would need only to fulfill the requirements in Paragraph (g) – Violent Incident Investigations and Recordkeeping with regard to documentation of significant contributing factors, recommendations, and corrective measures taken for each investigation -- which in turn would inform these employers’ annual review of incidents under Table E-2 row (i).

(f) Training

Education and training are key elements of a workplace violence prevention program and help to ensure that all staff members are aware of potential hazards and how to protect themselves and their coworkers through established policies and procedures. Training raises the overall safety and health knowledge across the workforce and provide employees with the tools necessary to identify workplace safety and security hazards. Training also helps to address potential problems
before they arise and can ultimately reduce the likelihood of workers being assaulted. OSHA solicits feedback on the following regulatory text regarding draft training requirements.

Under paragraph (f)(1), each employer would be required to institute a training program for all employees who have direct patient/client/resident contact, provide direct patient/client/resident care, or are responsible for workplace violence incident response duties, and their supervisory staff. Supervisors and managers would receive at least the same level of training as the staff they supervise. Supervisors and managers would be trained to recognize high-risk situations so they can ensure that workers are not placed in assignments that compromise their safety.

Under paragraph (f)(1)(i), OSHA would require that this training be provided initially (e.g., by the effective date of this standard), prior to the time of assignment (e.g., a new-hire), or when employees are newly-assigned to perform duties for which their previous training did not meet all requirement for the newly-assigned duties. If an employee had received workplace violence prevention training from the employer in the 12 months preceding the effective date of this standard, the employer would need only to provide additional training to the extent that the previous training did not meet the requirements of this standard.

For example, employers in California or Nevada—states that implemented workplace violence prevention regulations in 2017 and 2019, respectively—are likely to already have many employees already in compliance with substantial portions of the training described in this framework. Many other healthcare providers nationwide already maintain workplace violence prevention training programs as well.

Under paragraph (f)(1)(ii) and (iii), employers would need to provide annual training and supplemental training to address specific deficiencies when there are changes to any procedures or controls designed to address workplace violence. This supplemental training may be limited to addressing only these changes.

Supplemental training would also be required when inadequacies in an employee’s knowledge or work practices indicate that the employee has not retained the requisite understanding or skills. Supplemental training is also required when any other situation arises in which retraining is necessary to ensure employee protection from workplace violence.

Paragraph (f)(2) provides that the workplace violence prevention training would be required to be overseen or conducted by a person knowledgeable in the program’s subject matter as it relates to the workplace. For example, if training is provided from an outside vendor unfamiliar with the specific worksite, these instructors would need to be knowledgeable about the WVPP and how the program would be implemented in the workplace. An internal representative with such knowledge may also need to be in attendance at the sessions.
The training must consist of material appropriate in content and vocabulary to the educational level, literacy, and language of the employees trained. Many healthcare and social assistance employers have employees who speak and understand a variety of primary languages other than English and have a wide range of educational backgrounds. As such, any training provided by the employer would be required to be presented with content and language consistent with the educational level, literacy, and language of employees. The training would need to be provided at no cost to employees, meaning that employees would need to receive paid time for the training and the employer would be responsible for all other training costs. The training would also need to be at a reasonable time and place such that employee attendance would not be difficult.

Paragraph (f)(2) also requires that the training provide an opportunity for interactive questions and answers with a person knowledgeable in the program’s subject matter as it relates to the workplace. As discussed above, if training is provided from an outside vendor unfamiliar with the specific worksite, these instructors would need to be knowledgeable about how the program would be implemented in the workplace, and an internal representative with such knowledge may also need to be in attendance at the sessions.

OSHA envisions four different training levels, depending on the employees’ job duties, risk of exposure, and need to know certain information. The four training levels are as follows:

- **Level 1 (Paragraph (f)(3))**: The first tier of training would be for employees with direct patient/client/resident contact duties and their supervisors. These would be those employees who perform support work that requires them to be in patient care areas – environmental services staff, meal delivery, etc.

- **Level 2 (Paragraph (f)(4))**: The second tier of training would be designated for employees assigned with direct patient/client/resident care duties in non-high-risk services and their supervisors. These include employees who provide healthcare or social assistance services directly to patients or clients and have hands-on or face-to-face contact with patients. These employees would include nurses, nursing assistants, patient care assistants, physicians, emergency medical services employees, and social workers providing social assistance services in clients’ homes. For purposes of SBREFA, OSHA also considers security staff to belong in this category.

- **Level 3 (Paragraph (f)(5))**: The third and more advanced tier of training would be for employees with direct patient/client/resident care duties in high-risk services and their supervisors. These employees would receive the similar training as the category of employees as described above, but the distinction would be that they are performing duties within services or service areas that OSHA or an employer has deemed to be high-risk.
• Level 4 (Paragraph (f)(6)): The fourth and most-advanced tier of training would be required for employees who are reasonably expected to respond to incidents of workplace violence and their supervisors. These employees may include, e.g., security staff or incident response team members.

Each employer would need to carefully examine all employees’ job duties to determine the level of training required.

Paragraph (f)(3) contains the minimum initial requirements for Level 1 training of employees who have patient contact (not care) duties and their supervisors. OSHA expects that, at a minimum, training for employees with direct patient/client/resident contact duties (employees who perform support work that requires them to be in patient care areas – environmental services staff, meal delivery, etc.) and their supervisors must receive an introductory or general awareness level of instruction that contains the following elements:

• An accessible copy of this standard and an explanation of its contents;
• A general explanation of the risks of workplace violence that employees are reasonably anticipated to encounter in their jobs;
• How to recognize, initiate and respond to specific alerts, alarms, or other warnings about threats of workplace violence;
• The role of security personnel, if any;
• How and under which circumstances to report workplace violence incidents to law enforcement;
• An explanation of the employer’s violent incident reporting system and the employer’s anti-retaliatory policy;
• Resources available to employees for coping with workplace violence incidents, such as employee assistance programs;
• Standard operating procedures developed as part of the WVPP [from paragraph (c)] that are applicable to the employee’s duties;
• Instruction on the use of employer-provided equipment including alarms, communication devices, and PPE, as well as the limitations of this equipment;
• How to recognize threatening behaviors in others, techniques for when and how to safely attempt to de-escalate a violent situation; and
• When and how to seek assistance to respond to potentially escalating violence.

Under paragraph (f)(4), employees with direct patient/client/resident care duties in areas other than high-risk service areas, and their supervisors would receive a more intermediate level of instruction on the content specified in (f)(3) directly above. Additionally, under paragraph (f)(4), training would also include an introduction to self-defense strategies and techniques and instruction on how and when to assist others engaged with a violent patient/client/resident or visitor. This type of training may involve role-playing, simulations, and drills.
Under paragraph (f)(5), employees assigned with direct patient/client/resident care duties in high-risk services would receive the intermediate training described above, plus an explanation of the policies and procedures for workplace violence incidents, as well as the demonstration of practical techniques for using them. OSHA believes this additional training is warranted because these employees are at elevated risk of workplace violence due to the duties they perform in high-risk areas. This training may include simulations and drills with respect to de-escalation, chemical and physical restraint policies, and seclusion procedures, as applicable.

Under paragraph (f)(6), employees designated to respond to a workplace violence incident and their supervisors must receive an advanced level of instruction of the training described above, in addition to all SOPs that are applicable to incident response. This training may include advanced simulations and drills with respect to de-escalation, chemical and physical restraint policies, or seclusion procedures, as applicable.

OSHA expects that through the participation in these four separate tiers of trainings, employees and supervisors will receive the knowledge, skills, and abilities necessary to collaboratively identify and respond to workplace safety and security hazards. OSHA is not at this time proposing to require any specific number of hours of training for each tier.

Annual Retraining

Paragraph (f)(7) outlines draft requirements for annual retraining of employees in all four tiers. OSHA has preliminarily selected annual training because this periodicity is consistent with many other OSHA standards (OSHA, 2007), the current requirements of the Joint Commission (Joint Commission, 2021b), and consistent with the periodicity of training mentioned in by multiple commenters to the OSHA’s RFI on Prevention of Workplace Violence in Healthcare and Social Assistance (e.g., Exs. 0151-A-2, 0174, 0215, 0235, 0239). Annual retraining of these employees would include, at a minimum:

- Training on all of the SOPs developed as part of the WVPP that are applicable to the employee’s duties, including any changes that have been made in the past year;

- An explanation of the employer’s violent incident reporting system, including any changes to the system that have been made in the past year, and results of the reviews of the WVPP;

- Any resources available to employees for coping with workplace violence incidents, such as employee assistance programs; and

- Employees who received practical training on physical techniques and those employees’ supervisors shall be provided refresher training to review the topics included in the initial
training. OSHA envisions that those employees with direct-patient care duties and employees expected to respond to workplace violence incidents, along with their supervisors, would receive annual refresher training and practical demonstration of techniques consistent with those learned in the initial training.

**Training Records Retention**

Finally, draft paragraph (f)(8) would require training records to be created and maintained for at least one year. These records would contain training dates, the curricula covered, names and qualifications of trainers, and names and job titles of all persons in attendance. As with other OSHA training records requirements, these records could be maintained electronically or on paper.

**Violent Incident Investigation and Recordkeeping**

**Violent Incident Investigation**

Post-incident investigation is an important component of an effective violence prevention program, and the information obtained from these investigations can inform other elements of the employer’s WVPP. Investigating incidents of workplace violence thoroughly can provide insight into steps that can be taken to avoid future workplace violence incidents and associated injuries. The purpose of the investigation should be to identify the “root-cause” of the incident. Employers would document the significant contributing factors of workplace violence incidents and any recommendations received, and corrective measures decided upon and taken. OSHA also expects that such documentation would be used to inform any subsequent hazard assessments conducted in their establishment.

OSHA solicits feedback on the following regulatory text regarding violent incident investigation and recordkeeping. Under draft paragraph (g)(1), employers would be required to implement and maintain a written violent incident reporting system for employees to report each workplace violent incident. As noted in the definitions section, workplace violence incident means any violent act (including physical assault and threat of physical assault) directed toward persons at work or on duty by patients or their visitors. It may or may not result in injury.

Paragraph (g)(1)(i) would require covered employers to include procedures for employees to report a violent incident, a threat, or the existence of other workplace violence hazards at the site of patient/client/resident care in their violent incident reporting system. These would include incidents where no injury has occurred, such as a near-miss. These reports would be collected during an employee’s normally-scheduled working shift and would not require employees to take personal time during their off-hours.
Paragraph (g)(1)(ii) would require employers to include policies and procedures that prohibit the employer, or any other person, from discriminating or retaliating against an employee who reports a workplace violence incident. OSHA is considering this requirement to ensure that employees feel comfortable reporting workplace violence incidents.

Paragraph (g)(2) contains draft requirements for violent incident investigations. It would require an employer to establish procedures for investigating the circumstances surrounding each workplace violence incident and obtaining information from the employee(s) who experienced or observed the incident.

Paragraph (g)(2)(i) would require an employer to initiate an investigation as soon as practicable, but no later than 24 hours after notification that a workplace violence incident has occurred. In this time, the employer must conduct an investigation of each incident that includes, at least:

- A review of the circumstances of the incident;
- A determination of whether any controls or measures implemented pursuant to the WVPP were ineffective;
- A determination of whether additional measures could have prevented the incident;
- Determination of whether there is a continuing hazard, and if so, what measures are being taken to protect employees, using modifications of engineering controls, work practice controls, training, or other measures; and
- Solicitation of input from involved employees, their representatives (if applicable), and supervisors, about any significant contributing factors to the incident, risk, or hazard, and whether further corrective measures could have prevented the incident, risk, or hazard.

Paragraph (g)(2)(ii) would require that covered employers document the significant contributing factors, recommendations, and corrective measures taken for each investigation conducted under this paragraph, and incorporate into the additional hazard assessment as required in paragraph (d)(4) Additional hazard assessments.

Paragraph (g)(3) would require that, following a workplace violence incident in a service area or activity not previously identified as high-risk, the employer would need to assess the service area at issue and job functions or activities that may have placed employees at increased risk for workplace violence.

Paragraph (g)(3)(i) explains that any service or area with a workplace violence incident should be considered high-risk unless there is a written determination of why this designation is not appropriate.
Reassessments – Incidents of Workplace Violence Occurring in Service Areas Not Previously Identified as High-Risk

Paragraph (g)(3)(ii) explains that, when a service or area is newly-determined to be high-risk, the employer must conduct a reassessment of the area consistent with the assessment in paragraph (d)(4)(i) Additional hazard assessments – which in effect consists of a hazard assessment of the service area at issue for environmental hazards as consistent with in (d)(1)(vi), and implementation of the controls identified in paragraph (e)(2) and (e)(3).

Paragraph (g)(3)(ii) explains that this reassessment must be conducted within 30 days unless the employer demonstrates it is infeasible, in which case it must be completed as soon as possible.

Recordkeeping

OSHA is considering a series of provisions that would form the basis for the violent incident recordkeeping and evaluation component of the WVPP. Accurate records of injuries, illnesses, and workplace violence incidents (including those where the employee did not sustain an injury), can help employers better address the workplace violence hazard. These records also help employers identify any developing trends or patterns in particular locations, jobs, or departments. These data can allow employers to evaluate methods of hazard control, identify training needs, and develop solutions for an effective prevention program. Recordkeeping and evaluating the violence prevention program are necessary to determine its overall effectiveness and identify any deficiencies or changes that should be made.

Paragraph (g)(4) describes potential requirements for employers to maintain a violent incident log. OSHA defines the violent incident log as the systematic and ongoing documentation of each incident reported through the violent incident reporting system. The employer would be required to establish and maintain records of each workplace violence incident, by establishment and by relevant patient or client care unit, regardless of whether the incident meets the criteria for an OSHA recordable injury or illness under 29 CFR Part 1904 Recordkeeping and Reporting Occupational Injuries and Illnesses. In other words, this log is completely separate from the recordkeeping requirements of 29 CFR Part 1904.

For example, this new log would include a situation where a patient/client/resident swung an object at a healthcare provider and missed or threatened to hurt an employee. OSHA’s draft definition of workplace violence incident includes threats and near misses that do not result in injury. Although these incidents would not be recordable under 29 CFR Part 1904, they would need to be recorded on the violent incident log.

Paragraph (g)(4)(i) outlines specific draft requirements under consideration for the violent
incident log on multi-employer worksites. It specifies that the host employer would be required to record violent incidents affecting any contractors, vendors, staffing agencies, and licensed independent practitioners with privileges operating in the establishment.

Paragraph (g)(4)(ii) outlines potential elements that the violent incident log would be required to include. These include:

(A) Employee’s name(s);
(B) Hire date(s);
(C) The date, time, and location of the incident, and job titles of involved employee(s);
(D) A detailed description of the incident;
(E) A description of risk factors present at the time of the incident (e.g., whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, in a high crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances);
(F) The nature and extent of the employee’s injuries, if any;
(G) Whether the incident required medical attention;
(H) Whether there was injury requiring days away from work;
(I) Name of person(s) who committed the violence;
(J) Classification of the person(s) who committed the violence, including whether they were a patient or client, family member or associate of a patient or client, or any other appropriate classification; and
(K) Information about the person completing the log including their name, job title, phone number, email address, and the date completed.

Paragraph (g)(4)(iii) would require that certain information from the violent incident log be available upon request to all employees:

(A) The nature and extent of the employee’s injuries, if any;
(B) A detailed description of the incident;
(C) The date, time, and location of the incident, and job titles of involved employee(s);
(D) A description of risk factors or other circumstances at the time of the incident.
(E) Classification of the person(s) who committed the violence, including whether they were a patient or client, family member or associate of a patient or client, or any other appropriate classification; and
(F) This information relating to employee health must be used in a manner that protects the confidentiality of employees to the extent possible. The employer must omit any element of personal identifying information sufficient to allow identification of any person involved in a workplace violence incident, such as the person's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the person's identity.

OSHA does not intend to stipulate whether employers with multiple units are required to create individual incident logs on a unit-by-unit basis in addition to reporting into a centralized source. OSHA recognizes that many large employers might find that added benefits of effectiveness and
accuracy could occur through the maintenance and review of individual units providing specific services within varied locations, but OSHA leaves this discretion to the employer.

OSHA expects that the controlling host employer would also record violent incidents affecting any contractors, vendors, staffing agencies, and licensed independent practitioners with privileges operating on the premises not only on the host employer’s OSHA 300 Log, but also on the controlling host employer’s violent incident log. Additionally, the host employer would train, discuss, and communicate with both the contracted employees and the contracted employer the details of the WVPP for their establishment.

(h) Retention of Records

OSHA solicits feedback on the use of the below draft regulatory text on retention of records. Consistent with other OSHA standards, OSHA is considering a requirement that all records required by this section shall be provided upon request to employees, representatives designated by an individual employee, and the Assistant Secretary.

Paragraph (h)(1)(i) presents a draft requirement that records of annual WVPP reviews as required by paragraph (c), must be created and maintained for a minimum of three years.

Paragraph (h)(1)(ii) presents a draft requirement that records of workplace violence hazard assessment and control measures as required in paragraphs (d) and (e), Table E-1, or Table E-2, as applicable, must be created and maintained for three years, or for as long as there is an unresolved hazard mitigation project pending or still in progress.

Paragraph (h)(1)(iii) presents a draft requirement that training records as required in paragraph (f) must be created and maintained for a minimum of one year.

Paragraph (h)(1)(iv) presents a draft requirement that records of violent incidents, including violent incident investigation reports and violent incident log reports required by this paragraph be created and maintained for a minimum of three years. This paragraph further would require that:

(A) Establishment-wide violent incident records shall be provided to the Assistant Secretary upon request within next business day.

(B) Establishment-wide violent incident log reports, excluding employee names, contact information, and occupations, shall be provided to all of the following: any employees, their personal representatives, and their authorized representatives within the next business day.

(C) Violent incident records relating to a particular employee shall be provided to that employee and to anyone having written authorized consent of that employee within the next business day.
Consistent with other OSHA standards, OSHA expects that records required by this section would be provided upon request to employees, former employees, representatives designated by an individual employee, and the Assistant Secretary. OSHA also emphasizes that the violent incident reporting system shall not replace the employer’s obligations to comply with OSHA’s Recordkeeping and Reporting requirements in 29 CFR Part 1904. Injuries or illnesses that occur as a result of workplace violence may also be recordable on the OSHA 300 log. Work-related injuries or illnesses are recordable if they result in death, medical treatment beyond first aid, loss of consciousness, transfer to another job, or restriction of work (restricted work activity or days away from work). *See 29 CFR 1904.7(a).*

Paragraph (h) includes a note to clarify that the violent incident investigation reports and violent incident logs, as described above, do NOT replace the requirements for employers to comply with 29 CFR Part 1904.

(i) **Anti-Retaliation**

Paragraph (i)(1) would require employers to inform each employee that employees have a right to the protections required by this section, and that employers are prohibited from discharging or in any manner discriminating against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.

Paragraph (i)(2) would require that employers not discharge or in any manner discriminate against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.

Paragraph (i) includes a note to clarify that section 11(c) of the OSH Act also prohibits employers from discriminating against an employee for exercising rights under, or as a result of actions that are required by, this section. Section 11(c) also protects employees who file a safety and health complaint, or otherwise exercise any rights afforded by the OSH Act.

(j) **Effective Date of the Draft Standard**

OSHA’s draft standard indicates that all of the provisions of the final standard would become effective sixty days after the publication date. Employers would be expected to comply with all provisions of the final standard within six months after the publication date to provide adequate time for training, control implementation, and other compliance.
References


Section V. Industry Profile, Costs of Compliance, WPV Incident Analysis

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1. Industry Profile

1.1 Introduction

This chapter describes and estimates affected employers and workers in the Health Care and Social Assistance industry sector covered by the regulatory framework. The industry profile provides the number of entities, establishments, and employees in the covered subsectors, as well as corresponding breakdowns for small entities and very small entities. This chapter presents summary statistics of the profile. Refer to Appendix A for the underlying detailed methodology.

1.2 Scope of the Regulatory Framework

The draft standard applies to all employers with employees that work in:

- **Hospitals, including emergency departments.** This refers to general medical, surgical, and specialty hospitals primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with a wide variety of medical conditions. These establishments maintain inpatient beds and provide patients with food services. These hospitals have an organized staff of physicians and other medical staff to provide patient care services. This includes ambulatory services that are provided on hospital grounds;

- **Behavioral health care facilities,** including 1) psychiatric hospitals and residential behavioral health facilities, and 2) ambulatory mental health care and ambulatory substance abuse treatment centers. Psychiatric hospital means a hospital primarily engaged in providing diagnostic, medical treatment, and monitoring services for inpatients with mental illness or substance abuse disorders. Treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services. Ambulatory mental health facilities and ambulatory substance abuse centers primarily provide mental health services on an outpatient basis and include facilities such as offices of psychiatrists, psychologists, mental health specialists, mental health practitioners, or substance abuse centers;

- **Residential care facilities** provide residential care combined with nursing, supervisory, or other types of assistance as required by the residents. These include establishments providing inpatient nursing and rehabilitative services, where such care is generally provided for an extended period of time. These establishments have a permanent core staff of registered or licensed practical nurses who, along with other staff, provide nursing and continuous personal care services. This setting also includes establishments providing residential and personal care services for (1) the elderly and other persons who

---

11 “Entities” include private firms, nonprofits, and government organizations. An “establishment” is a single physical workplace. An entity may have multiple establishments. In this PIRFA, OSHA’s criteria for defining entities as “small” are based upon the U.S. Small Business Administration (SBA) size standards in accordance with the Regulatory Flexibility Act (RFA) as amended by the Small Business Regulatory Enforcement Fairness Act (SBREFA). “Very small entities” are defined in this PIRFA as enterprises with fewer than twenty employees.
are unable to care for themselves independently and/or (2) the elderly and other persons who do not desire to live independently. The care typically includes room, board, supervision, and assistance in daily living, such as housekeeping services. In some instances, these establishments provide skilled nursing care for residents in separate on-site facilities. These establishments generally provide a wide range of social services in addition to counseling: ¹²

- **Home health care**, including home-based social assistance. This includes any care or services provided at the patient/client/resident’s residence;
- **Social assistance**, where social assistance services are directly provided. This excludes child day care centers; and,
- **Emergency medical services**, including paramedics, emergency medical technicians (EMTs), and firefighters cross-trained and performing services as paramedics or EMTs.

Table 1 summarizes the individual NAICS codes covered by the scope of the draft standard in these six overall Healthcare Settings. ¹³

**Table 1. Healthcare Settings, by NAICS Code**

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>NAICS Description</th>
<th>NAICS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Behavioral Health Facilities</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>621112</td>
</tr>
<tr>
<td></td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td>621330</td>
</tr>
<tr>
<td></td>
<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td>621420</td>
</tr>
<tr>
<td></td>
<td>Psychiatric hospitals</td>
<td>622210</td>
</tr>
<tr>
<td></td>
<td>Residential Intellectual and Developmental Disability Facilities</td>
<td>623210</td>
</tr>
<tr>
<td></td>
<td>Residential Mental Health and Substance Abuse Facilities</td>
<td>623220</td>
</tr>
<tr>
<td>Hospitals, other than mental health</td>
<td>General medical and surgical hospitals</td>
<td>622110</td>
</tr>
<tr>
<td></td>
<td>Freestanding Ambulatory Surgical and Emergency Centers</td>
<td>621493</td>
</tr>
<tr>
<td></td>
<td>Specialty (except psychiatric and substance abuse) hospitals</td>
<td>622310</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>Nursing care facilities (skilled nursing facilities)</td>
<td>623110</td>
</tr>
<tr>
<td></td>
<td>Continuing Care Retirement Communities</td>
<td>623311</td>
</tr>
<tr>
<td></td>
<td>Assisted Living Facilities for the Elderly</td>
<td>623312</td>
</tr>
<tr>
<td></td>
<td>Other Residential Care Facilities</td>
<td>623990</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>Home health care services</td>
<td>621610</td>
</tr>
<tr>
<td></td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>624120</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>Child and Youth Services</td>
<td>624110</td>
</tr>
<tr>
<td></td>
<td>Other Individual and Family Services</td>
<td>624190</td>
</tr>
</tbody>
</table>

¹² These establishments do not include Residential Intellectual and Developmental Disability Facilities or Residential Mental Health and Substance Abuse Facilities, both of which are included in the scope of the behavioral health care facility setting.

¹³ Though most tables in this section are presented for these general healthcare settings, it is important to note that all calculations are actually done at the more detailed NAICS industry level and by ownership (private, non-profit, and government), and then aggregated to healthcare settings for presentation. Industry level tables are aggregated over ownership. See Appendix A for more results at the industry and industry-ownership level.
Healthcare Setting | NAICS Description | NAICS Code
--- | --- | ---
Community Food Services | 624210
Temporary Shelters | 624221
Other Community Housing Services | 624229
Emergency and Other Relief Services | 624230
Vocational Rehabilitation Services | 624310
Ambulance Services | 621910
Firefighter-EMTs | *

* NAICS 922160 includes government and volunteer firefighters, including those cross-trained as EMTs. Potentially affected private sector firefighter-EMTs are in entities typically classified under NAICS 561990. See Appendix A for discussion of how OSHA developed the profile this group.


1.3 Potentially Regulated Entities

OSHA uses a combination of data from the U.S. Census Bureau’s County Business Patterns (CBP), Bureau of Labor Statistics’ Quarterly Census of Employment and Wages (QCEW), and other sources to characterize potentially regulated firms, establishments, employees, and annual revenues. Some state- and local-government entities are outside of OSHA jurisdiction (those not in state-plan states) and are excluded from this analysis. Appendix A details OSHA’s methodology for constructing estimates using these data sources.

Table 2 summarizes the set of entities covered by the regulatory framework. OSHA estimates that approximately 201,700 entities would be subject to a workplace violence rule, including approximately 300,400 establishments and 14 million employees.

Table 2. Summary of Potentially Regulated Entities

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>Behavioral Health Facilities</th>
<th>Hospitals, other than mental health</th>
<th>Residential Care Facilities</th>
<th>Home Health Care Services</th>
<th>Social Assistance</th>
<th>Emergency Responders</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For profit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entities</td>
<td>41,202</td>
<td>4,777</td>
<td>24,289</td>
<td>39,132</td>
<td>9,828</td>
<td>2,332</td>
<td>121,561</td>
</tr>
<tr>
<td>Establishments</td>
<td>58,344</td>
<td>8,754</td>
<td>37,589</td>
<td>52,714</td>
<td>13,744</td>
<td>4,187</td>
<td>175,332</td>
</tr>
<tr>
<td>Employees</td>
<td>597,823</td>
<td>948,597</td>
<td>1,957,969</td>
<td>1,980,102</td>
<td>119,947</td>
<td>157,703</td>
<td>5,762,141</td>
</tr>
<tr>
<td><strong>Non-Profit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entities</td>
<td>11,460</td>
<td>1,995</td>
<td>6,254</td>
<td>11,931</td>
<td>35,755</td>
<td>995</td>
<td>68,391</td>
</tr>
<tr>
<td>Establishments</td>
<td>32,549</td>
<td>4,187</td>
<td>9,845</td>
<td>15,432</td>
<td>49,568</td>
<td>1,787</td>
<td>113,368</td>
</tr>
<tr>
<td>Employees</td>
<td>748,537</td>
<td>3,902,235</td>
<td>760,479</td>
<td>652,066</td>
<td>990,072</td>
<td>43,441</td>
<td>7,096,830</td>
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<td><strong>State and Local Government</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entities</td>
<td>2,007</td>
<td>925</td>
<td>697</td>
<td>510</td>
<td>1,799</td>
<td>5,808</td>
<td>11,747</td>
</tr>
<tr>
<td>Establishments</td>
<td>2,007</td>
<td>925</td>
<td>697</td>
<td>510</td>
<td>1,799</td>
<td>5,808</td>
<td>11,747</td>
</tr>
<tr>
<td>Employees</td>
<td>137,072</td>
<td>528,797</td>
<td>44,190</td>
<td>27,281</td>
<td>91,213</td>
<td>265,303</td>
<td>1,093,856</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entities</td>
<td>54,670</td>
<td>7,697</td>
<td>31,240</td>
<td>51,573</td>
<td>47,382</td>
<td>9,136</td>
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<tr>
<td>Establishments</td>
<td>92,900</td>
<td>13,866</td>
<td>48,131</td>
<td>68,656</td>
<td>65,111</td>
<td>11,782</td>
<td>300,447</td>
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<tr>
<td>Employees</td>
<td>1,483,432</td>
<td>5,379,629</td>
<td>2,762,638</td>
<td>2,659,449</td>
<td>1,201,232</td>
<td>466,447</td>
<td>13,952,827</td>
</tr>
</tbody>
</table>
Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.

1.4 Potentially Regulated Small Entities

This PIRFA will present costs and impacts for the following categories of entities based on size:

- All in-scope entities,
- Small entities, as defined by U.S. Small Business Administration (SBA) size standards in accordance with the Regulatory Flexibility Act (RFA) as amended by the Small Business Regulatory Enforcement Fairness Act (SBREFA), and
- Very small entities, defined as entities having fewer than 20 employees.

The SBA’s Table of Small Business Size Standards defines small business thresholds for each NAICS industry (SBA, 2019). These thresholds are entity-level (versus establishment) and, for private firms, depend on the industry and are generally based on either a firm’s total number of employees or total annual revenue. For in-scope private firms, all of the SBA small business thresholds are revenue-based, ranging from $8.0 to $41.5 million per year depending on the NAICS industry. Table 3 presents SBA-defined small entity/business thresholds for potentially affected NAICS industries.

Table 3. SBA Small Entity Thresholds for In-Scope NAICS Industries, Private Entities

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>NAICS Description</th>
<th>NAICS Code</th>
<th>SBA Small Business Threshold (Revenue, $Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Facilities</td>
<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td>621420</td>
<td>$16.5</td>
</tr>
<tr>
<td></td>
<td>Psychiatric and substance abuse hospitals</td>
<td>622210</td>
<td>$41.5</td>
</tr>
<tr>
<td></td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>621112</td>
<td>$12.0</td>
</tr>
<tr>
<td></td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td>621330</td>
<td>$8.0</td>
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<tr>
<td></td>
<td>Residential intellectual and developmental disability</td>
<td>623210</td>
<td>$16.5</td>
</tr>
<tr>
<td></td>
<td>Mental health, and substance abuse facilities</td>
<td>623220</td>
<td>$16.5</td>
</tr>
<tr>
<td>Hospitals, other than mental health</td>
<td>General medical and surgical hospitals</td>
<td>622110</td>
<td>$41.5</td>
</tr>
<tr>
<td></td>
<td>Freestanding Ambulatory Surgical and Emergency Centers</td>
<td>621493</td>
<td>$16.5</td>
</tr>
<tr>
<td></td>
<td>Specialty (except psychiatric and substance abuse)</td>
<td>622310</td>
<td>$41.5</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>Nursing care facilities (skilled nursing facilities)</td>
<td>623110</td>
<td>$30.0</td>
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<tr>
<td></td>
<td>Continuing Care Retirement Communities</td>
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<td>$30.0</td>
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<tr>
<td></td>
<td>Assisted Living Facilities for the Elderly</td>
<td>623312</td>
<td>$12.0</td>
</tr>
<tr>
<td></td>
<td>Other residential care facilities</td>
<td>623990</td>
<td>$12.0</td>
</tr>
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<td>Home Healthcare</td>
<td>Home health care services</td>
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<td>Social Assistance Facilities</td>
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<td>624110</td>
<td>$12.0</td>
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<td>Other Individual and Family Services</td>
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<td>Community Food Services</td>
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<td>Temporary Shelters</td>
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<td>Other Community Housing Services</td>
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<td>$16.5</td>
</tr>
<tr>
<td>Healthcare Setting</td>
<td>NAICS Description</td>
<td>NAICS Code</td>
<td>SBA Small Business Threshold (Revenue, $Millions)</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------------</td>
<td>------------</td>
<td>-------------------------------------------------</td>
</tr>
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<td>Healthcare Setting</td>
<td>Emergency and Other Relief Services</td>
<td>624230</td>
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<td>Vocational Rehabilitation Services</td>
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<td>Emergency Responders</td>
<td>Ambulance Services</td>
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</tr>
<tr>
<td></td>
<td>All Other Support Services</td>
<td>561990</td>
<td>$12.0</td>
</tr>
</tbody>
</table>

Source: SBA (2019).

The RFA defines small nonprofit organizations as those that are not dominant in their field, and small governmental jurisdictions (sometimes referred to as “small governments” in this analysis) as those that serve a population of less than 50,000. For purposes of SBREFA and other analyses directed by the RFA, OSHA considers all nonprofits as fitting the RFA definition of small non-profits. For government organizations, local-government entities that are located in counties with population under 50,000 are the basis for estimating RFA-defined small governments.

The third set of estimates for very small entities (those with fewer than 20 employees) were obtained from the 2017 CBP data, as described in Appendix A.

Table 4 presents, for each healthcare setting, the number of entities, establishments, and employees by size category: all sizes, SBA/RFA-defined small entities, and very small entities. These data include all ownership categories. OSHA preliminarily estimates that approximately 186,000 small entities, employing about 10 million employees, may be affected by this potential rule. Of these SBA/RFA-defined small entities, 128,000 are very small entities employing fewer than 20 people. Nearly 572,000 employees work for very small entities covered by this potential rule.

Table 4. In-Scope Total, Small, and Very Small Entities

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>All Sizes</th>
<th>SBA/RFA-Defined Small</th>
<th>Very Small</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Entities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Facilities</td>
<td>54,670</td>
<td>52,174</td>
<td>42,934</td>
</tr>
<tr>
<td>Hospitals, other than mental health</td>
<td>7,697</td>
<td>6,277</td>
<td>2,746</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>31,240</td>
<td>29,434</td>
<td>15,897</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>51,573</td>
<td>50,020</td>
<td>32,108</td>
</tr>
<tr>
<td>Social Assistance Facilities</td>
<td>47,382</td>
<td>45,614</td>
<td>33,460</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>9,136</td>
<td>8,497</td>
<td>2,643</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>201,698</td>
<td>192,016</td>
<td>129,788</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Establishments</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Facilities</td>
<td>92,900</td>
<td>81,576</td>
<td>43,389</td>
</tr>
</tbody>
</table>


15 Even though OSHA considers all non-profits, regardless of revenue size, to be small entities according to the RFA definition, OSHA also keeps track of which non-profit entities meet the revenue criteria applied to for-profit entities so that entities are differentiated by the size of their operation (versus RFA designation) for the purposes of costing. Many cost inputs in the analysis are a function of facility size, so OSHA wants to maintain this characterization of non-profit entities for the cost analysis.
1.5 Direct Patient/Client/Resident Care and Contact Employees

The regulatory framework distinguishes between general employees covered by the draft rule and those who are at greater risk and are required to receive specific training on workplace violence. The framework requires training for each worker who provides direct patient/client/resident care, has direct patient/client/resident contact, has workplace violence incident response duties, and their supervisory staff:

- **Direct patient/client/resident care** means job duties that involve the delivery of healthcare services or social assistance services with hands-on or face-to-face contact with patients or clients. Workers who provide direct patient/client/resident care include nurses, physicians, technicians, home care workers visiting client homes, as well as workers providing emergency medical services.

- **Direct patient/client/resident contact** means job duties where workers perform support work that requires them to be in patient/client/resident care areas. Such work includes housekeeping, maintenance, meal delivery, and information technology. For purposes of SBREFA, OSHA also considers security staff to belong in this category.

To estimate the number of direct patient/client/resident care and contact (PCCC) employees for each healthcare setting, OSHA uses the Bureau of Labor Statistics’ (BLS) most recent Occupational Employment Statistics (OES) dataset, which provides NAICS-specific estimates of employment by occupation (BLS, 2019). Within the general Healthcare and Social Assistance sector, OES includes 485 unique occupations, including both healthcare and non-healthcare occupations. Of these, OSHA identified 80 occupations that fit within the definition for direct patient/client/resident care, 10 occupations with direct patient/client/resident contact (but not care), and 10 occupations of associated supervisory staff, based on a review of BLS’ occupation descriptions. The list of occupations is included in Appendix B to this report. OSHA then
calculated the proportion of employees in these categories for each NAICS code. OSHA assumes that all employees in facilities with five or fewer total employees are direct patient/client/resident care and contact employees.

Table 5 presents the resulting estimates of the number of direct patient/client/resident care and contact employees, by healthcare setting. There is a range of 66 to 86 percent of employees in the affected settings working in these occupations, with the large majority being patient/client/resident care (versus contact-only). The home healthcare setting has the highest individual proportion of employees in direct patient/client/resident care occupations of the six settings, at 86 percent of employees, while social assistance is the lowest at 66 percent. OSHA estimates that approximately 10.4 million in-scope employees work in direct PCCC occupations. Approximately 3.8 million PCCC employees work in SBA-defined small business entities and about 487,000 PCCC employees are in very small entities.

Table 5. Employees in Direct Patient/client/resident Care or Contact (PCCC) Occupations

<table>
<thead>
<tr>
<th>Setting and Ownership</th>
<th>Percent of Employees in Care or Contact Occupations</th>
<th>Direct Care Occupation Employees</th>
<th>Direct Contact Occupation Employees</th>
<th>Total Direct Care or Contact Occupation Employees</th>
<th>Total Direct Care or Contact Employees in SBA/RFA-Defined Small Entities</th>
<th>Total Direct Care or Contact Employees in Very Small Entities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Facilities</td>
<td>67%</td>
<td>1,089,039</td>
<td>76,732</td>
<td>1,165,771</td>
<td>607,323</td>
<td>113,405</td>
</tr>
<tr>
<td>Hospitals, other than mental health</td>
<td>68%</td>
<td>3,356,951</td>
<td>276,339</td>
<td>3,633,291</td>
<td>239,493</td>
<td>12,097</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>78%</td>
<td>1,756,197</td>
<td>403,694</td>
<td>2,159,892</td>
<td>1,035,269</td>
<td>66,345</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>86%</td>
<td>2,269,836</td>
<td>20,688</td>
<td>2,290,524</td>
<td>1,271,399</td>
<td>142,468</td>
</tr>
<tr>
<td>Social Assistance Facilities</td>
<td>66%</td>
<td>710,122</td>
<td>61,173</td>
<td>771,295</td>
<td>506,040</td>
<td>132,775</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>79%</td>
<td>363,801</td>
<td>142</td>
<td>363,943</td>
<td>205,396</td>
<td>19,881</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9,545,947</strong></td>
<td><strong>838,768</strong></td>
<td><strong>10,384,715</strong></td>
<td><strong>3,864,921</strong></td>
<td><strong>486,971</strong></td>
<td></td>
</tr>
</tbody>
</table>

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

Direct patient/client/resident care/contact employees are employees at higher risk of workplace violence due to their closer proximity and work with the serviced population. In Appendix B, OSHA presents the occupations identified by the agency as direct patient/client/resident care/contact employees. To calculate employment shares of these categories by industry, OSHA uses the Bureau of Labor Statistics’ (BLS) most recent Occupational Employment Statistics (OES), which provides industry-specific estimates of employment by occupation (BLS, 2019). For each NAICS code, OSHA estimated the proportion of employees in patient/client/resident care and patient/client/resident contact occupations, including their supervisors, and applied these industry-level proportions to the CBP-based estimates of employment. This resulted in estimates of the number of employees, by industry, in these specific occupations.

Table 6 presents the estimated number of patient/client/resident care and contact employees per establishment for each ownership category: for-profit, non-profit, state government, and local government establishments, respectively. These data are key inputs for the analyses of unit costs.
for provisions in the draft rule affecting PCCC employees. As noted earlier in this section, the
draft regulatory framework requires training for each worker who provides direct
patient/client/resident care, has direct patient/client/resident contact, has workplace violence
incident response duties, and their supervisory staff. Section 2.5 below discusses OSHA’s
methodology for assigning unit training hours to PCCC employees, employees with workplace
violence incident response duties, and supervisory staff in the agency’s training cost model.
### Table 6. Number of Direct Patient/Client/Resident Care or Contact Employees per Facility

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large</th>
<th>SBA/RFA-Defined Small</th>
<th>Very Small</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For-Profit Facilities</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>NA</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td>NA</td>
<td>4</td>
<td>2</td>
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<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td>15</td>
<td>9</td>
<td>4</td>
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<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical and Emergency Centers</td>
<td>18</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>68</td>
<td>23</td>
<td>5</td>
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<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>41</td>
<td>26</td>
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<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
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<td>80</td>
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<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
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<td>126</td>
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<tr>
<td>622310</td>
<td>Specialty (except Psychiatric and Substance Abuse) Hospitals</td>
<td>125</td>
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<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
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<td>68</td>
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<tr>
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<td>Residential Intellectual and Developmental Disability Facilities</td>
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<td>Continuing Care Retirement Communities</td>
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<tr>
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<tr>
<td>624110</td>
<td>Child and Youth Services</td>
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<td>Other Individual and Family Services</td>
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<tr>
<td>624221</td>
<td>Temporary Shelters</td>
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<td>624229</td>
<td>Other Community Housing Services</td>
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<tr>
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<td>2</td>
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<td>624310</td>
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<td><strong>Non-Profit Facilities</strong></td>
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<td></td>
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<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
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<td>10</td>
<td>4</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td>NA</td>
<td>6</td>
<td>4</td>
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<tr>
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<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td>33</td>
<td>18</td>
<td>4</td>
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<tr>
<td>621493</td>
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<td>42</td>
<td>6</td>
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<td>621910</td>
<td>Ambulance Services</td>
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<td>17</td>
<td>8</td>
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<td>General Medical and Surgical Hospitals</td>
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<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
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<td>Residential Intellectual and Developmental Disability Facilities</td>
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<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
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<td>97</td>
<td>7</td>
</tr>
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</table>
### Table 6. Number of Direct Patient/Client/Resident Care or Contact Employees per Facility

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Direct Patient/Client/Resident Care or Contact Employees per Facility</th>
<th>State-Government Facilities</th>
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</thead>
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<td>SBA/RFA-Defined Small</td>
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<tr>
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<td>Other Residential Care Facilities</td>
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<td>624120</td>
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<td>23</td>
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<td>624190</td>
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<tr>
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<td>Community Food Services</td>
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</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>NA</td>
<td>10</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>NA</td>
<td>7</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
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<td>4</td>
</tr>
<tr>
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<td>Vocational Rehabilitation Services</td>
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<td>19</td>
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<td><strong>State-Government Facilities</strong></td>
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<td>621112</td>
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<td>Offices of Mental Health Practitioners (except Physicians)</td>
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</tr>
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<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>123</td>
<td>6</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual and Developmental Disability Facilities</td>
<td>65</td>
<td>23</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse Facilities</td>
<td>36</td>
<td>8</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>98</td>
<td>7</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>28</td>
<td>7</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>46</td>
<td>13</td>
</tr>
<tr>
<td>624120</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>131</td>
<td>16</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>65</td>
<td>18</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Firefighter-EMTs</td>
<td>37</td>
<td>10</td>
</tr>
</tbody>
</table>
### Table 6. Number of Direct Patient/Client/Resident Care or Contact Employees per Facility

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

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

Compliance cost estimates for each of the requirements under the potential rule are detailed in the following sections. Several sources were used to derive these estimates, including publicly-available data from federal agencies and other sources (e.g., trade associations), as well as conversations with industry sector subject matter experts. Agency judgment was also used when no available data source could be found.

Many employers are already taking a number of measures that would be required by the potential rule even absent a new regulation. OSHA considers this level of compliance to constitute the “baseline” from which additional costs are measured. OSHA’s analysis of total costs accounting for baseline compliance activity is described in Chapter 3.

The unit cost estimates presented here are “from scratch,” as if an affected employer had no cost elements in place. For example, the unit cost of a hazard assessment is calculated based on the average amount of time it would take to perform the assessment based on facility type and size and other factors. This is a fixed average cost; OSHA does then reduce that unit cost to account for the fact that some employers may have already gathered some of the information necessary for the hazard assessment. If OSHA determines that certain employers are already performing the full hazard assessment even before required to do so by an OSHA standard, then this will constitute baseline compliance and OSHA would not apply a cost to those employers. But anything less than full compliance will result in a full unit cost applied to that employer.

In the cost analysis, OSHA often compares “large” and “small” facility types. OSHA uses RFA’s definition of small entity or organization except that OSHA considers all non-profit entities to be small (SBA, 2019). Because the RFA’s definition for small non-profit organizations is that they be not dominant in their field, all non-profit organizations, including very large organizations, are considered small by this SBA criterion. For purposes of estimating cost impacts, OSHA assigned the private for-profit size criteria to non-profit entities in the applicable affected NAICS groups and for analytical convenience the agency applied the SBA revenue thresholds to small non-profit entities. By mapping the size distribution patterns of private entities to non-profit entities, OSHA could then apply per-entity revenue estimates to non-profits from the overall revenue distribution for private entities published in the 2017 CBP See Appendix A for more details. 16

16 County Business Patterns (CBP) is an annual series published by the U.S. Census Bureau that provides subnational economic data by industry. The CBP series includes the number of establishments, employment during a given week, first quarter payroll, and annual payroll.

As discussed in Appendix A, the 2017 CBP data include entity revenue by employment size category. OSHA uses these data to estimate the average revenue per firm, by NAICS code and employment-size category. OSHA first identifies the SBA-designated revenue threshold for each NAICS. Next, OSHA aggregates the number of firms across employment-sizes for all firms with average revenue below the applicable SBA revenue threshold. The result of that calculation was the number of SBA-defined small private firms by NAIACS code. For this PIRFA, OSHA estimated the percentage of firms that are small for each NAICS code, and applied that percentage to the number of affected for-profit entities to estimate the number of affected small for-profit entities. To estimate the number of affected small non-profit entities, OSHA applied the simplifying assumption that revenue distribution patterns among non-profit entities were identical to those among for-profit entities.
2.1 Labor Rates

All of the potential rule’s provisions include compliance elements that require a labor burden for regulated entities, which is monetized using labor rates for relevant occupations associated with any given compliance activity. To estimate wages and total labor rates, OSHA used the BLS OES, which provides average wage rates by NAICS industry and occupation (BLS, 2019).

OSHA estimated weighted-average hourly wages, by NAICS code, for all employees and subsets of occupations required for the analysis, including supervisors and managers, direct patient/client/resident care and contact employees, and training specialists. The average wages for “patient/client/resident care,” “patient/client/resident contact,” “supervisor/manager,” and “training specialist” employees were determined by taking the weighted average of wages of BLS Standard Occupational Classification (SOC) occupational classifications within each of those four employee groups. For the details on the calculation of weighted averages for the four occupation categories noted above, see OSHA, 2022 [Excel workbook], tab “Occupation and Wages”, columns R-V, and tab “BLS OES 2018.”

Supervisor/manager wages reflect the diversity of key leadership anticipated to participate in the compliance activities under the potential rule, such as the development of policies and procedures, implementation of hazard assessments, participation in training, incident response, investigation of incidents, and other elements as specified in subsequent sections of this chapter. As described earlier in this Industry Profile (Section 1.5, above), OSHA identified 80 occupations that fit within the definition for direct patient care and 10 occupations associated with direct patient contact (but not care), based on a review of BLS’ occupation descriptions. See Appendix B for a list of occupations included for supervisors and direct/client care and contact employees.

OSHA estimated total labor rates by adjusting base wages to account for other employer labor costs, including benefits and other direct employer obligations. The agency’s estimated percentages for benefits and other direct employer obligations were calculated from data reported in BLS’ Employer Cost of Employee Compensation (ECEC) describing wages as a percentage of total compensation for hospitals (64.9 percent) and other healthcare settings (69.3 percent) (BLS, 2019b). For this PIRFA, OSHA calculated a “loaded wage” which included a fringe benefit rate ranging from 28 percent of total compensation to 39 percent of total compensation (depending on the healthcare setting and occupational category) and an overhead rate when estimating the marginal cost of labor in its primary cost calculation. Overhead costs are indirect expenses that cannot be tied to producing a specific product or service. Common examples include rent, utilities, and office equipment. There is no general consensus on the cost elements that fit this definition, which has led to a wide range of overhead estimates. For this PIRFA, OSHA applied an overhead rate of 17 percent of base wages.

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17 See OSHA, 2023 [Excel workbook], tabs “Occupations & Wages” and “BLS ECC”.
18 The methodology was modeled after an approach used by the U.S. Environmental Protection Agency. More information on this approach can be found at U.S. Environmental Protection Agency, “Wage Rates for Economic Analyses of the Toxics Release Inventory Program,” June 10, 2002. This analysis was based on a survey of several large chemical manufacturing plants: Heiden Associates, Final Report: A Study of Industry Compliance Costs Under the Final Comprehensive Assessment Information Rule, Prepared for the Chemical Manufacturers Association, December 14, 1989. This is consistent with the overhead rate used for sensitivity analyses in the 2017 Improved Tracking Final Economic Analysis (FEA) and the FEA in support of OSHA’s 2016 final standard on Occupational Exposure to Respirable Crystalline Silica.
Labor rates do not vary by entity size or ownership category. Table 7 presents total hourly labor costs by NAICS industry and employee category.

Table 7. Labor Rates for Facility Employees, by NAICS industry ($/hr.)

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>All Employees</th>
<th>Patient/Client Care</th>
<th>Patient/Client Contact</th>
<th>Supervisors/Managers</th>
<th>Training Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>$64.94</td>
<td>$84.67</td>
<td>$21.17</td>
<td>$91.17</td>
<td>$51.58</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td>$50.04</td>
<td>$55.87</td>
<td>$22.82</td>
<td>$86.26</td>
<td>$51.22</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td>$42.09</td>
<td>$41.66</td>
<td>$22.94</td>
<td>$75.26</td>
<td>$44.21</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical and Emergency Centers</td>
<td>$50.07</td>
<td>$52.98</td>
<td>$23.84</td>
<td>$80.84</td>
<td>$49.78</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>$32.92</td>
<td>$30.77</td>
<td>$23.08</td>
<td>$77.17</td>
<td>$55.69</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services (and Firefighter-EMTs)</td>
<td>$32.71</td>
<td>$29.19</td>
<td>$23.35</td>
<td>$76.16</td>
<td>$48.09</td>
</tr>
<tr>
<td>62210</td>
<td>General Medical and Surgical Hospitals</td>
<td>$51.47</td>
<td>$55.67</td>
<td>$23.61</td>
<td>$95.53</td>
<td>$54.85</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>$45.03</td>
<td>$46.27</td>
<td>$26.31</td>
<td>$85.40</td>
<td>$47.75</td>
</tr>
<tr>
<td>62230</td>
<td>Specialty (except Psychiatric and Substance Abuse) Hospitals</td>
<td>$52.73</td>
<td>$51.66</td>
<td>$23.65</td>
<td>$98.15</td>
<td>$57.27</td>
</tr>
<tr>
<td>62310</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>$32.61</td>
<td>$33.57</td>
<td>$20.61</td>
<td>$73.46</td>
<td>$52.27</td>
</tr>
<tr>
<td>62320</td>
<td>Residential Intellectual and Developmental Disability Facilities</td>
<td>$25.15</td>
<td>$22.89</td>
<td>$23.42</td>
<td>$41.01</td>
<td>$37.67</td>
</tr>
<tr>
<td>62322</td>
<td>Residential Mental Health and Substance Abuse Facilities</td>
<td>$33.10</td>
<td>$30.97</td>
<td>$22.66</td>
<td>$60.21</td>
<td>$44.23</td>
</tr>
<tr>
<td>62331</td>
<td>Continuing Care Retirement Communities</td>
<td>$26.96</td>
<td>$26.12</td>
<td>$20.72</td>
<td>$60.09</td>
<td>$47.46</td>
</tr>
<tr>
<td>62332</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>$26.96</td>
<td>$26.12</td>
<td>$20.72</td>
<td>$60.09</td>
<td>$47.46</td>
</tr>
<tr>
<td>62390</td>
<td>Other Residential Care Facilities</td>
<td>$29.85</td>
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<td>$23.37</td>
<td>$51.25</td>
<td>$42.67</td>
</tr>
<tr>
<td>62410</td>
<td>Child and Youth Services</td>
<td>$27.32</td>
<td>$24.52</td>
<td>$21.99</td>
<td>$53.61</td>
<td>$40.60</td>
</tr>
<tr>
<td>62412</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>$24.21</td>
<td>$22.60</td>
<td>$21.29</td>
<td>$47.76</td>
<td>$37.50</td>
</tr>
<tr>
<td>62419</td>
<td>Other Individual and Family Services</td>
<td>$27.32</td>
<td>$24.52</td>
<td>$21.99</td>
<td>$53.61</td>
<td>$40.60</td>
</tr>
<tr>
<td>62420</td>
<td>Community Food Services</td>
<td>$35.26</td>
<td>$30.45</td>
<td>$23.28</td>
<td>$59.21</td>
<td>$41.78</td>
</tr>
<tr>
<td>62421</td>
<td>Temporary Shelters</td>
<td>$35.26</td>
<td>$30.45</td>
<td>$23.28</td>
<td>$59.21</td>
<td>$41.78</td>
</tr>
<tr>
<td>62422</td>
<td>Other Community Housing Services</td>
<td>$35.26</td>
<td>$30.45</td>
<td>$23.28</td>
<td>$59.21</td>
<td>$41.78</td>
</tr>
<tr>
<td>62423</td>
<td>Emergency and Other Relief Services</td>
<td>$35.26</td>
<td>$30.45</td>
<td>$23.28</td>
<td>$59.21</td>
<td>$41.78</td>
</tr>
<tr>
<td>62431</td>
<td>Vocational Rehabilitation Services</td>
<td>$29.05</td>
<td>$26.07</td>
<td>$21.58</td>
<td>$56.02</td>
<td>$36.95</td>
</tr>
</tbody>
</table>


Table 8 presents average hourly labor costs, aggregated to the healthcare settings.
Table 8. Labor Rates for Facility Employees, by Setting ($/hr.)

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>All Covered Employees</th>
<th>Direct Patient/Client Care</th>
<th>Direct Patient/Client Contact</th>
<th>Direct Patient/Client Care or Contact</th>
<th>Supervisors/Managers</th>
<th>WPV Training Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Facilities</td>
<td>$50.82</td>
<td>$58.21</td>
<td>$23.71</td>
<td>$56.68</td>
<td>$68.62</td>
<td>$45.68</td>
</tr>
<tr>
<td>Hospitals, other than mental health</td>
<td>$51.51</td>
<td>$55.47</td>
<td>$23.61</td>
<td>$53.01</td>
<td>$95.37</td>
<td>$54.89</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>$30.50</td>
<td>$31.05</td>
<td>$20.82</td>
<td>$29.13</td>
<td>$65.85</td>
<td>$49.55</td>
</tr>
<tr>
<td>Social Assistance Facilities</td>
<td>$28.80</td>
<td>$25.18</td>
<td>$22.18</td>
<td>$24.96</td>
<td>$55.50</td>
<td>$38.43</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>$32.71</td>
<td>$29.19</td>
<td>$23.35</td>
<td>$29.18</td>
<td>$76.16</td>
<td>$48.09</td>
</tr>
</tbody>
</table>

Source: BLS (2019a, 2019b), OSHA analysis.

The unit cost analysis for each provision draws on the labor rates presented above in Table 7 to monetize labor burden estimates for the various potential provisions, as described in the following sections. Note that for the cost analysis of any regulation, the agency uses averages as the appropriate measures, including the estimates for labor rates and labor burdens (hours), for calculating total costs. Of course, individual facilities will have their own individual characteristics; however, what is important for total costs is whether on average the estimates are reasonable. As with all aspects of this analysis, the agency encourages comment and input from SERs on the accuracy of the estimates in this PIRFA, including suggestions of any data and datasets that will better inform the agency’s analysis.

2.2 Workplace Violence Prevention Program (WVPP)

Paragraph (c) of the regulatory framework, Workplace Violence Prevention Program (WVPP), requires employers to develop, implement, and maintain a written WVPP. The WVPP contains several elements for which OSHA estimates one-time and subsequent annual review labor burdens, as applicable. OSHA then incorporates labor rates to estimate per-facility costs of compliance for paragraph (c).

Requirements provided in paragraph (c) of the regulatory framework include facilitating communication regarding the implementation of the WVPP; ensuring active involvement of employees and their representatives in developing, implementing, and reviewing the WVPP; and establishing requirements for contractors, vendors, staffing agencies, and licensed independent practitioners to adhere to the host employer’s WVPP (paragraph (c)(2)(i) – (vi)). These elements together will be called “WVPP background.”

Paragraph (c)(2)(ii) of the regulatory framework requires establishing effective policies and procedures, pursuant to paragraph (e), control measures, including:

- Workplace violence incident response procedures, including the appropriate use of restraints in accordance with state and local law (paragraph (e)(1)(ii)(D)); and,

- The evaluation of each new and returning patient/client/resident, including procedures for effective communication to staff of a patient/client/resident’s history or potential for violence (paragraph (e)(1)(iv)).
Paragraph (c)(2)(iii) of the regulatory framework requires establishing effective policies and procedures, pursuant to paragraph (g), violent incident investigation and recordkeeping, including:

- Violent incident recordkeeping, including written procedures for employees to report a violent incident, threat, or other WPV hazards (paragraph (g)(1)(i)); and,
- Violent incident investigation, including procedures to investigate the circumstances surrounding each WPV incident (paragraph (g)(2)).

For this PIRFA, OSHA estimated the labor burden for each of the above activities, by NAICS industry, facility size, and ownership (facility size varies by ownership). Labor burdens for each activity and facility category were estimated using a combination of direct patient/client/resident care and contact employment data, and best professional judgment with input from agency technical staff and subject experts.

2.2.1 WVPP Background Development

OSHA estimated a labor burden requirement for WVPP background elements, paragraphs (c)(2)(i) and (c)(2)(iv)—(vii), for large facilities, as shown in Table 9. For example, for the initial development of these elements of the WVPP, OSHA estimated that large general and psychiatric hospitals will require a total of 40 hours of labor.

Table 9. Labor Burden Assumptions for Development of WVPP Background, under Paragraph (c)(2)(i)—(vi) – Large Facilities

<table>
<thead>
<tr>
<th>NAICS Description</th>
<th>NAICS</th>
<th>[Managers]</th>
<th>[Employees]</th>
<th>[Total]</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical and Surgical Hospitals (Other Hospitals, excluding Behavioral)</td>
<td>622110</td>
<td>30</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Psychiatric and Substance Abuse Hospitals (Behavioral Health)</td>
<td>622210</td>
<td>30</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Nursing Care Facilities (Residential Care)</td>
<td>623110</td>
<td>20</td>
<td>8</td>
<td>28</td>
</tr>
<tr>
<td>Residential Intellectual and Developmental Disability Facilities (Behavioral Health)</td>
<td>623210</td>
<td>12</td>
<td>6</td>
<td>18</td>
</tr>
</tbody>
</table>


Next, OSHA estimated the labor burden for large facilities in the remaining NAICS codes by scaling these labor burden estimates based on facilities’ relative sizes. For this analysis, the size of facilities, by NAICS industry, was measured by the number of direct patient/client/resident care and contact (PCCC) employees per facility (see Table 10). This metric for facility size was used as a proxy for estimating the cost of all of the elements (facility physical size, patient mix, etc.) that employers will need to address in the WVPP.

Then, because the affected NAICS across healthcare settings have a unique “base” NAICS industry against which to adjust in accordance with the number of PCCC employees, OSHA scaled affected employment in relation to the “base” NAICS industry. For example, the affected NAICS in the Other Hospital setting were based on the General Medical and Surgical Hospital labor burden and size. Large, for-profit General Medical and Surgical Hospitals have an average of 522 PCCC employees while large Specialty Hospitals have 125. The derived estimate of total hours for WVPP background development for large Specialty Hospitals is 9.5 hours ((125/522 =
24%) x 40 hours (estimated number of labor hours for large general and psychiatric hospitals to develop the WVPP) = 9.5 hours.) Similarly, OSHA scaled other NAICS in the Behavioral Health setting based on the Residential Intellectual and Developmental Disability Facilities labor burden and size, and OSHA scaled all other NAICS based on the Nursing Care Facility profile.

Table 10. Number of Direct Patient/Client/Resident Care or Contact Employees per Establishment

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Patient/Client/Resident Care or Contact Employees (PCCC) per Establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>Large 37 Small 4 Very Small 2</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td>Large 26 Small 14 Very Small 4</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td>Large 19 Small 10 Very Small 5</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical and Emergency Centers</td>
<td>Large 73 Small 24 Very Small 5</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>Large 36 Small 23 Very Small 6</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>Large 860 Small 136 Very Small 3</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>Large 281 Small 79 Very Small 2</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>Large 97 Small 71 Very Small 4</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual and Developmental Disability Facilities</td>
<td>Large 16 Small 14 Very Small 5</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>Large 34 Small 17 Very Small 5</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>Large 108 Small 51 Very Small 5</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>Large 41 Small 12 Very Small 4</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>Large 26 Small 14 Very Small 5</td>
</tr>
<tr>
<td>624120</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>Large 30 Small 11 Very Small 5</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>Large 89 Small 23 Very Small 4</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>Large 34 Small 10 Very Small 4</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>Large 7 Small 4 Very Small 4</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>Large 22 Small 4 Very Small 4</td>
</tr>
<tr>
<td>624310</td>
<td>Firefighter-EMTs</td>
<td>Large 32 Small 16 Very Small 3</td>
</tr>
</tbody>
</table>

NA = no establishments

For the other facility sizes, SBA-defined small and very small, OSHA estimated the labor burden for each NAICS industry based on the relative size to large facilities in the specific NAICS. In addition, all labor estimates for NAICS industries in the Home Healthcare and Emergency Responder settings were assigned a 50 percent reduction in their initial estimates to account for the lack of a physical facility for these entities.

2.2.2 Policy and Procedure Development

OSHA analyzed costs for two other elements of the WVPP. OSHA estimated the labor burden for development of the policies and procedures in paragraphs (e) Control measures and (g)
Violent incident investigation and recordkeeping of the draft regulatory framework, which are required by paragraphs (c)(2)(ii) and (c)(2)(iii).

OSHA estimates that creating standard operating procedures for the development and implementation of control measures required by paragraph (c)(2)(ii) is equal to the number of hours for the WVPP background elements of (c) described above. Based on OSHA’s professional judgement and consultations with subject matter experts (Abt, 2020), the agency estimates that the development of standard operating procedures for incident investigation and recordkeeping required by paragraph (c)(2)(iii) is equal to half of this same WVPP background development burden.

2.2.3 WVPP Review

Paragraph (c)(3) of the regulatory framework requires employers to review and update the WVPP at least annually and whenever necessary to reflect changes in the workplace that indicate a need to revise policies. The review includes evaluation of all data recorded in the violence incident log and incident investigations in addition to any other records and information pertaining to the implementation and effectiveness of the WVPP. OSHA assumes that the burden for this activity is equal to half of the initial WVPP background burden.

The development and implementation of the WVPP under paragraph (c) will be supported by supervisor/manager employees as well as direct patient/client care and contact employees. OSHA allocated a portion of the estimated labor burdens to these labor categories, with twice the share of the burden assigned to supervisors/managers versus direct patient/client/resident care and contact employees.

2.2.4 Total Per-Facility WVPP Development Burden and Cost

Table 11 summarizes the resulting facility-level labor burdens for paragraph (c) of the regulatory framework. The burden estimates in Table 11 vary based on NAICS, ownership, and size, following the approach outlined above. The table summarizes the results across ownership categories, weighted by the number of facilities in each NAICS industry by ownership. Large general and psychiatric hospitals have the highest burden, at an estimated average of 100 hours initially, and 20 hours annually for the WVPP review. OSHA assumes facilities have an initial minimum of one-hour of labor, where the size-scaling approach otherwise produces an estimate below one hour in total burden.

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

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>One-Time</td>
<td>Annual</td>
<td>One-Time</td>
<td>Annual</td>
<td>One-Time</td>
</tr>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>14.4</td>
<td>2.9</td>
<td>11.4</td>
<td>2.3</td>
<td>7.9</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td>41.7</td>
<td>8.3</td>
<td>14.5</td>
<td>2.9</td>
<td>7.2</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td>67.6</td>
<td>13.5</td>
<td>37.9</td>
<td>7.6</td>
<td>11.5</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical and Emergency Centers</td>
<td>3.4</td>
<td>0.7</td>
<td>1.9</td>
<td>0.4</td>
<td>1.0</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>26.7</td>
<td>5.3</td>
<td>9.0</td>
<td>1.8</td>
<td>1.8</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>12.6</td>
<td>2.5</td>
<td>6.6</td>
<td>1.3</td>
<td>2.2</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>100.0</td>
<td>20.0</td>
<td>17.3</td>
<td>3.5</td>
<td>1.0</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>100.0</td>
<td>20.0</td>
<td>47.1</td>
<td>9.4</td>
<td>1.5</td>
</tr>
</tbody>
</table>
Labor burdens were monetized using the corresponding labor rates for management and direct patient/client/resident care and contact employees per Table 7 above. Table 12 presents OSHA’s estimates of average per-facility compliance costs for paragraph (c) of the regulatory framework, which includes both one-time and annual review costs.

**Table 12. Total Per-Facility Cost for Paragraph (c), $2019 (all ownerships)**
<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>One-Time</th>
<th>Annual</th>
<th>One-Time</th>
<th>Annual</th>
<th>One-Time</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>$1,446</td>
<td>$289</td>
<td>$450</td>
<td>$90</td>
<td>$154</td>
<td>$31</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>$707</td>
<td>$141</td>
<td>$380</td>
<td>$76</td>
<td>$139</td>
<td>$28</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>$828</td>
<td>$166</td>
<td>$314</td>
<td>$63</td>
<td>$135</td>
<td>$27</td>
</tr>
<tr>
<td>624120</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>$1,250</td>
<td>$250</td>
<td>$327</td>
<td>$65</td>
<td>$59</td>
<td>$12</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>$944</td>
<td>$189</td>
<td>$268</td>
<td>$54</td>
<td>$116</td>
<td>$23</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>$220</td>
<td>$44</td>
<td>$123</td>
<td>$25</td>
<td>$132</td>
<td>$26</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>NA</td>
<td>NA</td>
<td>$290</td>
<td>$58</td>
<td>$114</td>
<td>$23</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>$86</td>
<td>$17</td>
<td>$188</td>
<td>$38</td>
<td>$92</td>
<td>$18</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>$653</td>
<td>$131</td>
<td>$126</td>
<td>$25</td>
<td>$120</td>
<td>$24</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>$794</td>
<td>$159</td>
<td>$460</td>
<td>$92</td>
<td>$91</td>
<td>$18</td>
</tr>
<tr>
<td></td>
<td>Firefighter-EMTs</td>
<td>$785</td>
<td>$157</td>
<td>$131</td>
<td>$26</td>
<td>$54</td>
<td>$11</td>
</tr>
</tbody>
</table>

NA = no establishments

Table 13 presents, by facility size, labor burden and cost per-facility aggregated across NAICS industries within each healthcare setting.

Table 7. Total Per-Facility Cost for Paragraph (c), by Setting, ($2019, all ownerships)

<table>
<thead>
<tr>
<th>Healthcare Setting and Size</th>
<th>WVPP Development Labor Burden per Facility</th>
<th>WVPP Development Cost per Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One-Time</td>
<td>Annual Recurring</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>55.2</td>
<td>11.0</td>
</tr>
<tr>
<td>Small</td>
<td>26.8</td>
<td>5.4</td>
</tr>
<tr>
<td>Very Small</td>
<td>8.6</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Other Hospitals (excluding BH)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>51.2</td>
<td>10.2</td>
</tr>
<tr>
<td>Small</td>
<td>6.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Very Small</td>
<td>1.0</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Residential Care Facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>53.6</td>
<td>10.7</td>
</tr>
<tr>
<td>Small</td>
<td>23.7</td>
<td>4.7</td>
</tr>
<tr>
<td>Very Small</td>
<td>3.1</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Social Assistance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>17.3</td>
<td>3.5</td>
</tr>
<tr>
<td>Small</td>
<td>6.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Very Small</td>
<td>2.5</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Home Healthcare Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>28.2</td>
<td>5.6</td>
</tr>
<tr>
<td>Small</td>
<td>8.5</td>
<td>1.7</td>
</tr>
</tbody>
</table>
### Healthcare Setting and Size

<table>
<thead>
<tr>
<th>Healthcare Setting and Size</th>
<th>WVPP Development Labor Burden per Facility</th>
<th>WVPP Development Cost per Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One-Time</td>
<td>Annual Recurring</td>
</tr>
<tr>
<td>Very Small</td>
<td>1.6</td>
<td>0.3</td>
</tr>
<tr>
<td>Large</td>
<td>12.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Small</td>
<td>4.6</td>
<td>0.9</td>
</tr>
<tr>
<td>Very Small</td>
<td>1.7</td>
<td>0.3</td>
</tr>
</tbody>
</table>


#### 2.3 Workplace Violence Hazard Assessment

Paragraph (d) of the regulatory framework, Workplace Violence Hazard Assessment, specifies requirements for initial establishment-wide and high-risk area hazard assessments, including documenting the assessment, under paragraphs (d)(1)(ii) – (vi). Paragraph (d)(1)(iii) requires a review of all WPV incidents in the previous three years. Paragraph (d)(3) requires employers to perform a re-assessment pursuant to (d)(1) annually. In addition, paragraph (d)(4) requires employers with employees in fixed-facility sites to conduct additional hazard assessments in response to workplace violence incidents, as specified in paragraph (g)(3).

Paragraph (d)(1)(vi) requires a hazard assessment for high-risk service areas. These high-risk areas include emergency rooms/emergency admissions/triage areas, psychiatric care areas, behavioral health care areas, substance abuse treatment areas, home healthcare, social assistance, emergency medical services, and other areas deemed to be of high-risk for violence by the employer.

The regulatory framework also specifies that paragraph (d) does not apply to employers in the home healthcare or home-based social assistance, emergency medical services employers, or staffing agencies. These employers do not operate fixed-facility sites of care, and are instead subject to an alternative set of hazard assessment requirements specified in Table E-1 and Table E-2 of the regulatory framework. Based on these specifications, all employers in these industries are required to perform an abbreviated initial general hazard assessment and a three-year review of previous WPV incidents. In addition, these employers are not required to perform the subsequent high-risk area hazard assessment, under paragraph (d)(1)(vi) or the incident-related hazard assessments under paragraph (d)(4). For the purposes of SBREFA costing, behavioral health facilities have been assumed to not perform incident-related hazard assessments under (d)(4)(i) since the entirety of the facility is designated as high-risk, and such assessments are only required for incidents that occur outside of previously designated high-risk areas.

To summarize, there are four hazard assessment requirements for which OSHA estimates unit costs:

1. Historical three-year incident review under (d)(1)(iii)
2. Establishment-wide assessment under (d)(1)(ii) – (iv)
3. High-risk service area assessment under (d)(1)(vi)
4. Additional hazard assessments under (d)(4)
All four components are performed annually.

2.3.1 WPV Incident Review

Under paragraph (d)(1)(iii), the employer must review all workplace violence incidents within the previous three years, regardless of whether an employee sustained an injury. OSHA estimated the annual cost per facility of this provision by starting with the average number of WPV incidents per facility, per year, by NAICS, ownership, and size, based on OSHA’s incident analysis, described in Appendix C. These incidents include all four incident types in the analysis: lost-work injuries, other recordable (OSHA 300 log) injuries, non-recordable injuries, and threats. Table 14 summarizes the average number of incidents per facility per year, across all ownership categories.19

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large</th>
<th>Small</th>
<th>Very Small</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>0.2</td>
<td>0.00*</td>
<td>0.00*</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>0.4</td>
<td>0.02</td>
<td>0.01</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>0.4</td>
<td>0.16</td>
<td>0.04</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical and Emergency</td>
<td>0.2</td>
<td>0.12</td>
<td>0.05</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>0.3</td>
<td>0.10</td>
<td>0.02</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>0.3</td>
<td>0.17</td>
<td>0.05</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>36.9</td>
<td>4.8</td>
<td>0.1</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>164.0</td>
<td>31.2</td>
<td>1.7</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric and Substance)</td>
<td>16.2</td>
<td>2.4</td>
<td>0.1</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>2.6</td>
<td>1.6</td>
<td>0.1</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual and Developmental Disability</td>
<td>3.6</td>
<td>1.1</td>
<td>0.8</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>4.9</td>
<td>1.6</td>
<td>0.5</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>2.0</td>
<td>0.8</td>
<td>0.1</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>0.7</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>14.6</td>
<td>2.2</td>
<td>1.2</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>5.7</td>
<td>0.6</td>
<td>0.4</td>
</tr>
<tr>
<td>624120</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>1.6</td>
<td>0.3</td>
<td>0.1</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>1.4</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>0.1</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>NA</td>
<td>0.18</td>
<td>0.07</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>0.3</td>
<td>0.2</td>
<td>0.05</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>0.4</td>
<td>0.05</td>
<td>0.03</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>1.8</td>
<td>0.6</td>
<td>0.14</td>
</tr>
</tbody>
</table>

19 To correct for underreporting of recordable lost-workday incidents, based on professional judgment, OSHA estimated that recorded lost-workday incidents represent 50 percent of all potentially recordable lost-workday incidents, including unreported incidents. This adjustment increases incidents by eighteen percent (reported incidents / 0.50 = 2.0 * reported incidents). Based on this adjustment, the incidence rates, covered employees, and the FTE adjustment (see Appendix C), OSHA estimated the resulting number of lost-workday WPV incidents, by NAICS, ownership, and facility size, shown by size and setting in Table C-6.
Next, OSHA multiplied the quantity of annual incidents by three as an estimate for the three-year lookback that the review requires, and assigned a burden of 10 minutes per incident for the review. Table 15 presents OSHA’s estimates of per-facility compliance costs for the three-year incident review under paragraph (d)(1)(iii) of the regulatory framework. This review, in future years, will be a mix of incidents previously reviewed as well as new incidents that have been recorded. These costs recur annually pursuant to paragraph (d)(3) where the prior three (3) years’ worth of incident records are reviewed each year. The burden was monetized using supervisor/manager wages. OSHA invites comments by SERs on the unit cost estimates presented in this PIRFA for WPV incident review.

### Table 9. WPV Incident Review Burden and Cost per Facility, First Year, all Ownships

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large Hours</th>
<th>Large Cost</th>
<th>Small Hours</th>
<th>Small Cost</th>
<th>Very Small Hours</th>
<th>Very Small Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>0.1</td>
<td>$9</td>
<td>0.0</td>
<td>$0.2</td>
<td>0.0</td>
<td>$0.1</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>0.2</td>
<td>$17</td>
<td>0.0</td>
<td>$0.9</td>
<td>0.0</td>
<td>$0.5</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>0.2</td>
<td>$13</td>
<td>0.1</td>
<td>$5.9</td>
<td>0.0</td>
<td>$1.5</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical and Emergency</td>
<td>0.1</td>
<td>$9</td>
<td>0.1</td>
<td>$4.7</td>
<td>0.0</td>
<td>$2.2</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>0.1</td>
<td>$10</td>
<td>0.0</td>
<td>$3.5</td>
<td>0.0</td>
<td>$0.6</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>0.1</td>
<td>$11</td>
<td>0.1</td>
<td>$6.7</td>
<td>0.0</td>
<td>$1.9</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>18.5</td>
<td>$1,765</td>
<td>2.4</td>
<td>$229.1</td>
<td>0.0</td>
<td>$3.9</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>82.0</td>
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<td>15.6</td>
<td>$1,333.5</td>
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<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric and Substance)</td>
<td>8.1</td>
<td>$796</td>
<td>1.2</td>
<td>$115.5</td>
<td>0.1</td>
<td>$5.8</td>
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<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>1.3</td>
<td>$95</td>
<td>0.8</td>
<td>$60.4</td>
<td>0.0</td>
<td>$3.4</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual and Developmental Disability</td>
<td>1.8</td>
<td>$74</td>
<td>0.6</td>
<td>$22.9</td>
<td>0.4</td>
<td>$16.8</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>2.4</td>
<td>$146</td>
<td>0.8</td>
<td>$47.1</td>
<td>0.3</td>
<td>$16.3</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>1.0</td>
<td>$59</td>
<td>0.4</td>
<td>$25.3</td>
<td>0.0</td>
<td>$2.7</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>0.4</td>
<td>$22</td>
<td>0.1</td>
<td>$6.3</td>
<td>0.0</td>
<td>$2.2</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>7.3</td>
<td>$375</td>
<td>1.1</td>
<td>$57.2</td>
<td>0.6</td>
<td>$31.4</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
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<td>0.3</td>
<td>$15.2</td>
<td>0.2</td>
<td>$10.4</td>
</tr>
<tr>
<td>624120</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>0.8</td>
<td>$38</td>
<td>0.2</td>
<td>$7.9</td>
<td>0.0</td>
<td>$1.5</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>0.7</td>
<td>$38</td>
<td>0.1</td>
<td>$3.0</td>
<td>0.0</td>
<td>$1.9</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>0.1</td>
<td>$4</td>
<td>0.0</td>
<td>$2.4</td>
<td>0.0</td>
<td>$1.4</td>
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<td>624221</td>
<td>Temporary Shelters</td>
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<td>0.1</td>
<td>$7.6</td>
<td>0.0</td>
<td>$3.0</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>0.1</td>
<td>$8</td>
<td>0.1</td>
<td>$4.9</td>
<td>0.0</td>
<td>$2.3</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>0.2</td>
<td>$12</td>
<td>0.0</td>
<td>$2.3</td>
<td>0.0</td>
<td>$1.2</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>0.9</td>
<td>$51</td>
<td>0.3</td>
<td>$18.2</td>
<td>0.1</td>
<td>$3.5</td>
</tr>
<tr>
<td>624310</td>
<td>Firefighter-EMTs</td>
<td>0.8</td>
<td>$58</td>
<td>0.1</td>
<td>$5.9</td>
<td>0.0</td>
<td>$3.0</td>
</tr>
</tbody>
</table>

Source: See Appendix C

NA = no establishments;
* = appears as zero due to rounding
2.3.2 Establishment-Wide Hazard Assessment

Each employer must conduct an assessment to identify environmental and organizational workplace violence risk factors. This includes an assessment of the level of crime in the surrounding community where services are being rendered, per (d)(1)(iv).

OSHA estimated the labor burden per facility as a function of facility size, where for hospitals and nursing homes, facility size was measured by the total number of beds for a given facility. Here, because the assessment was more directly based on physical characteristics of the facility, the agency used total beds as a proxy where practicable versus using the number of PCCC employees as a proxy (see above, WVPP development). OSHA obtained an estimate of the average number of beds per hospital (NAICS 622110), for all reporting hospitals, and the average number of beds per psychiatric hospital (NAICS 622210), from the American Hospital Association’s (AHA) 2019 Hospital Statistics Survey (AHA 2019). For nursing homes (NAICS 623110), OSHA obtained an estimate of the average number of beds from the National Center for Health Statistics (CDC, 2019).

Next, to allocate beds per facility by facility size, OSHA applied the estimates from the industry profile for the total number of employees per facility in the three affected NAICS codes, for the overall average facility by industry and by facility size (large, small, very small). Because the assessment was facility wide, in the agency’s estimation, total employees (versus PCCC employees) was the better proxy. OSHA then estimated the average number of beds per facility by size – large, small, and very small – for the three affected industries based on ratio of employment in these size categories to the overall average.

Table 16 summarizes the estimated number of beds per facility for the three affected industries, as well as average employees per facility. These data for beds and facilities were used as the inputs in subsequent analyses specifying facility size for the other affected NAICS industries.

For the remaining affected industries, the facility-wide assessment burden is estimated based on their employment size using the number of patient care and contact employees per establishment (see Table 9). In this case, the agency scales by size using the number of PCCC employees, rather than total employees, since this subset of employees drives the costs associated with the hazard assessment requirements. Specifically, other industries in the Other Hospital setting are estimated based on employment size relative to the hospitals inputs (622110); other industries in the behavioral health setting are estimated relative to the psychiatric hospital inputs (622210); and all other industries are estimated relative to the nursing home inputs (623110). This results in an estimate of the number of beds or bed-equivalents for each NAICS code, by facility size (large, small, and very small).

---

20 “See OSHA, 2023 [Excel workbook], tabs “Profile_Private” and “Profile_Government.””
Table 10. Average Beds per Facility, all Ownerhips

<table>
<thead>
<tr>
<th>Facility Type and Size</th>
<th>Beds per Facility</th>
<th>Employees per Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Hospital (NAICS 622110)</td>
<td>150</td>
<td>931</td>
</tr>
<tr>
<td>Large</td>
<td>196</td>
<td>1216</td>
</tr>
<tr>
<td>Small</td>
<td>31</td>
<td>192</td>
</tr>
<tr>
<td>Very Small</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Psychiatric Hospital (NAICS 622210)</td>
<td>60</td>
<td>98</td>
</tr>
<tr>
<td>Large</td>
<td>70</td>
<td>115</td>
</tr>
<tr>
<td>Small</td>
<td>51</td>
<td>84</td>
</tr>
<tr>
<td>Very Small</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Nursing Home (NAICS 623110)</td>
<td>135</td>
<td>291</td>
</tr>
<tr>
<td>Large</td>
<td>166</td>
<td>359</td>
</tr>
<tr>
<td>Small</td>
<td>78</td>
<td>169</td>
</tr>
<tr>
<td>Very Small</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>


Lastly, OSHA specifies the level of effort associated with the facility-wide assessment in terms of a minutes-per-bed measure: 20 minutes per bed (or bed-equivalent). OSHA recognizes that the assessment itself is not strictly limited to beds, but the measure is used as a proxy to capture relevant variation in facility size, similar to several other measures. Labor for the home healthcare and emergency medical response industries is further reduced by 50 percent due to the absence of a fixed physical worksite. Based on the assumption that staff in management positions, broadly defined, would be mainly involved in facilitating and carrying-out assessments (e.g. working with/arranging inspections/hiring consultants to conduct the assessments), OSHA calculated the dollar value of labor by assuming a mix of management labor and employee labor, with 75 percent allocated to management.

Table 17 summarizes facility-level labor burdens and costs for the facility-wide hazard assessment. These assessments recur annually pursuant to paragraph (d)(3), but OSHA assumes that the level of effort and associated costs is reduced by half following the first-year assessment.

Table 11. Facility-Wide Hazard Assessment Burden and Cost per Facility, all Ownerhips

<p>| NAICS   | NAICS Description                              | Large | | | Small | | | Very Small | | |
|---------|-----------------------------------------------|-------|---|---|-------|---|---|---|---|
| 621112  | Offices of Physicians, Mental Health Specialists | 9     | $776 | 1 | $62  | 0.4 | $32  |
| 621330  | Offices of Mental Health Practitioners         | 10    | $803 | 1 | $70  | 0.3 | $27  |
| 621420  | Outpatient Mental Health and Substance Abuse   | 5     | $340 | 3 | $168 | 0.6 | $41  |
| 621493  | Freestanding Ambulatory Surgical and Emergency | 2     | $161 | 1 | $92  | 0.6 | $48  |
| 621610  | Home Health Care Services                      | 9     | $583 | 3 | $194 | 0.5 | $35  |
| 621910  | Ambulance Services                              | 4     | $271 | 2 | $143 | 0.6 | $41  |
| 622110  | General Medical and Surgical Hospitals         | 65    | $5,542 | 10 | $874 | 0.3 | $28  |</p>
<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large</th>
<th></th>
<th></th>
<th>Small</th>
<th></th>
<th></th>
<th>Very Small</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hours</td>
<td>Cost</td>
<td>Hours</td>
<td>Cost</td>
<td>Hours</td>
<td>Cost</td>
<td>Hours</td>
<td>Cost</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>55</td>
<td>$4,168</td>
<td>26</td>
<td>$1,962</td>
<td>0.7</td>
<td>$50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric and Substance)</td>
<td>16</td>
<td>$1,415</td>
<td>8</td>
<td>$654</td>
<td>0.3</td>
<td>$25</td>
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</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>23</td>
<td>$1,471</td>
<td>17</td>
<td>$1,074</td>
<td>0.9</td>
<td>$56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual and Developmental Disability</td>
<td>5</td>
<td>$184</td>
<td>3</td>
<td>$97</td>
<td>1.1</td>
<td>$41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>7</td>
<td>$393</td>
<td>3</td>
<td>$168</td>
<td>0.8</td>
<td>$42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>23</td>
<td>$1,199</td>
<td>11</td>
<td>$559</td>
<td>1.1</td>
<td>$56</td>
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</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>10</td>
<td>$495</td>
<td>3</td>
<td>$153</td>
<td>0.9</td>
<td>$46</td>
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<td></td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
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<td>3</td>
<td>$128</td>
<td>0.9</td>
<td>$40</td>
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</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>6</td>
<td>$283</td>
<td>2</td>
<td>$106</td>
<td>0.8</td>
<td>$38</td>
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</tr>
<tr>
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<td>Services for the Elderly and Persons with Disabilities</td>
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<td>$426</td>
<td>3</td>
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<td>0.4</td>
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<td></td>
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<tr>
<td>624190</td>
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<td>2</td>
<td>$91</td>
<td>0.7</td>
<td>$33</td>
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</tr>
<tr>
<td>624210</td>
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<td>$75</td>
<td>1</td>
<td>$42</td>
<td>0.7</td>
<td>$37</td>
<td></td>
<td></td>
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<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>NA</td>
<td>NA</td>
<td>2</td>
<td>$98</td>
<td>0.6</td>
<td>$32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>1</td>
<td>$29</td>
<td>1</td>
<td>$64</td>
<td>0.5</td>
<td>$26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>624230</td>
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<td>$43</td>
<td>0.7</td>
<td>$34</td>
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<td></td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>6</td>
<td>$271</td>
<td>3</td>
<td>$157</td>
<td>0.6</td>
<td>$27</td>
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<td></td>
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<td>3</td>
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<td>$64</td>
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<td></td>
</tr>
</tbody>
</table>

NA = no establishments

2.3.3 High-Risk Area Hazard Assessments

In addition to the hazards and risk factors in paragraph (d)(1)(v), the employer must also separately assess all high-risk service areas under paragraph (d)(1)(vi). This assessment should consider a broad set of risk factors related to access, communication, illumination, and other physical environment, patient/client/resident-related, and employer-identified organizational risks.

OSHA estimated the labor burden for the high-risk service area hazard assessment using the same general approach as the facility-wide hazard assessment, with the following modifications:

- OSHA estimated that the high-risk assessment labor burden is equal to 20 percent of the facility-wide burden. This estimate is intended to reflect that high-risk service areas subject to the additional inspection in many cases comprise a relatively small proportion of the overall facility. For affected employers included in the behavioral health setting,

21 For example, data from National Mental Health Services Survey, 2018, indicate that there are 34,367 inpatient beds in psychiatric units within general hospitals, and the AHA survey (2019) shows a total of 893,019 beds in general hospitals overall (both surveys exclude Federal facilities). These results suggest that about 3.8 percent of general hospital beds are relatively high-risk and thus are associated with an average high-risk-assessment burden that is lower than the facility-wide assessment burden. Psychiatric care areas are analyzed in this example for illustrative purposes. As discussed earlier in this PIRFA, high-risk areas profiled for OSHA’s cost model include emergency rooms/emergency admissions/triage areas, psychiatric care areas, behavioral health care areas.
however, the agency assumed that the entire facility is comprised of high-risk service areas; and,

- Home healthcare and home-based social assistance, and emergency responders are not subject to this requirement and therefore incur no cost.

Table 18 summarizes facility-level labor burden and cost for the high-risk service area hazard assessment. These assessments recur annually pursuant to paragraph (d)(3), but OSHA assumes that the level of effort and associated costs is reduced by half following the first year assessment.

### Table 12. High-Risk Service Area Hazard Assessment Burden and Cost per Facility, all Ownerships

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large</th>
<th></th>
<th>Small</th>
<th></th>
<th>Very Small</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hours</td>
<td>Cost</td>
<td>Hours</td>
<td>Cost</td>
<td>Hours</td>
<td>Cost</td>
</tr>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>8.68</td>
<td>$776</td>
<td>0.70</td>
<td>$62</td>
<td>0.36</td>
<td>$32</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>10.22</td>
<td>$803</td>
<td>0.88</td>
<td>$70</td>
<td>0.34</td>
<td>$27</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>5.09</td>
<td>$340</td>
<td>2.52</td>
<td>$168</td>
<td>0.62</td>
<td>$41</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical and Emergency</td>
<td>0.44</td>
<td>$32</td>
<td>0.25</td>
<td>$18</td>
<td>0.13</td>
<td>$10</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>13.05</td>
<td>$1,108</td>
<td>2.06</td>
<td>$175</td>
<td>0.07</td>
<td>$6</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>55.43</td>
<td>$4,168</td>
<td>26.09</td>
<td>$1,962</td>
<td>0.67</td>
<td>$50</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric and Substance)</td>
<td>3.29</td>
<td>$283</td>
<td>1.52</td>
<td>$131</td>
<td>0.06</td>
<td>$5</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>10.51</td>
<td>$662</td>
<td>7.67</td>
<td>$483</td>
<td>0.40</td>
<td>$25</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual and Developmental Disability</td>
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<td>$184</td>
<td>2.66</td>
<td>$97</td>
<td>1.12</td>
<td>$41</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>7.48</td>
<td>$393</td>
<td>3.19</td>
<td>$168</td>
<td>0.81</td>
<td>$42</td>
</tr>
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<td>623311</td>
<td>Continuing Care Retirement Communities</td>
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<td>4.91</td>
<td>$252</td>
<td>0.49</td>
<td>$25</td>
</tr>
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<td>$69</td>
<td>0.40</td>
<td>$21</td>
</tr>
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<td>623990</td>
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<td>2.40</td>
<td>$108</td>
<td>1.28</td>
<td>$58</td>
<td>0.40</td>
<td>$18</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>1.22</td>
<td>$57</td>
<td>0.46</td>
<td>$21</td>
<td>0.17</td>
<td>$8</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>1.39</td>
<td>$64</td>
<td>0.39</td>
<td>$18</td>
<td>0.14</td>
<td>$7</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>0.29</td>
<td>$15</td>
<td>0.16</td>
<td>$8</td>
<td>0.14</td>
<td>$7</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>-</td>
<td>NA</td>
<td>0.38</td>
<td>$20</td>
<td>0.12</td>
<td>$6</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>0.11</td>
<td>$6</td>
<td>0.25</td>
<td>$13</td>
<td>0.10</td>
<td>$5</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>0.86</td>
<td>$45</td>
<td>0.17</td>
<td>$9</td>
<td>0.13</td>
<td>$7</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>1.12</td>
<td>$54</td>
<td>0.65</td>
<td>$31</td>
<td>0.11</td>
<td>$5</td>
</tr>
</tbody>
</table>

NA = no establishments

### 2.3.4 Additional Hazard Assessments

Under paragraph (d)(4), each employer must conduct additional hazard assessments in response to workplace violence incidents as specified in paragraph (g)(3). Following a workplace violence substance abuse treatment areas, home healthcare, social assistance, emergency medical services, and other areas deemed to be of high-risk for violence by the employer.
incident in a service area or activity not previously identified as high-risk, the employer must assess the service area at issue as well as the job functions or activities that may have placed employees at increased risk for workplace violence. The area where the incident occurred could subsequently be designated as high-risk based on an assessment consistent with paragraph (d)(1)(v), and may therefore result in the need for additional engineering controls, consistent with paragraphs (e)(2) and (e)(3). For purposes of SBREFA costing, behavioral health facilities have been assumed to not perform incident-related hazard assessments under (d)(4) since the entirety of the facility is designated as high-risk, and such assessments are only required for incidents that occur outside of previously designated high-risk areas.

OSHA estimated the burden associated with these incident-related assessments based on data from OSHA incident analysis (Appendix C). Applying professional judgment, OSHA estimated that 5 percent of WPV incidents annually occur outside of previously designated high-risk areas and therefore would be subject to the assessment requirement. OSHA estimated that the per-incident assessment will require two hours of manager labor for a lost-work incident resulting in day(s) away from work\(^{22}\) and one hour of manager labor for all other types of incidents.

The cost for incident-related hazard assessments under (d)(4)(i) potentially includes the need for additional engineering control equipment if the incident area is newly designated as high-risk. To estimate this additional possible cost, OSHA estimated that 5 percent of the relevant incidents result in newly designated high-risk service areas (i.e., 0.25 percent of all incidents, since incidents that occur outside previous high-risk areas are already a 5 percent subset of all incidents). For this small set of incidents resulting in newly designated high-risk service areas, OSHA estimated that affected areas will require engineering control costs equal to 5 percent of total per-facility engineering control costs (engineering control costs are discussed in Section 2.4.5, below).

In contrast to OSHA’s access to published data on workplace violence incidents and WPV incidence rates, the agency lacked available data indicating the nature or frequency of physical changes in the layout, design, or amenities of the workplace that could increase the risk of workplace violence ((d)(4)(ii)); or, changes in clientele or services provided that could increase the risk of workplace violence ((d)(4)(iii)). OSHA did not quantify costs associated with additional assessments required as a result of these changes when they occur. OSHA believes that such changes (e.g., services, physical layout) are relatively uncommon compared to incidence of WPV for a typical healthcare facility, and therefore OSHA is capturing the majority of potential additional assessment costs under (d)(4)(i)–(iii) by quantifying incident-related assessment costs. OSHA invites comments from SERs on this preliminary assessment of compliance costs under (d)(4).

Table 19 summarizes the per-incident cost for a single lost-work incident that occurs outside of a high-risk service area, triggering an incident-related hazard assessment for applicable NAICS industries.

Table 13. Cost per Lost-Work Incident for Incident Hazard Assessment, all Ownerships

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\(^{22}\) This includes days away with or without a job transfer or restriction.
Table 20 summarizes total per-facility burden and cost for incident-related hazard assessments, aggregated on a facility-weighted basis across all ownership categories, based on the estimated number of incidents per facility that will require a hazard assessment.

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large</th>
<th>Small</th>
<th>Very Small</th>
</tr>
</thead>
<tbody>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>$88</td>
<td>$85</td>
<td>$83</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>$356</td>
<td>$137</td>
<td>$97</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>$151</td>
<td>$128</td>
<td>$99</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>$125</td>
<td>$108</td>
<td>$75</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>$128</td>
<td>$91</td>
<td>$62</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>$80</td>
<td>$66</td>
<td>$62</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>$64</td>
<td>$58</td>
<td>$54</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>$72</td>
<td>$59</td>
<td>$57</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>$79</td>
<td>$58</td>
<td>$58</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>$63</td>
<td>$61</td>
<td>$61</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>NA</td>
<td>$62</td>
<td>$61</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>$61</td>
<td>$61</td>
<td>$61</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>$70</td>
<td>$61</td>
<td>$61</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>$67</td>
<td>$64</td>
<td>$57</td>
</tr>
</tbody>
</table>


NA = no establishments; results of 0.00 hours are due to rounding.
Table 21 presents OSHA’s estimates of total per-facility costs to comply with paragraph (d) of the regulatory framework. In OSHA’s preliminary cost model, hazard assessments recur annually, per paragraph (d)(3), although the cost model projects that 50 percent less effort will be required for assessments following the first year.

Table 14. Total Per-Facility Hazard Assessment Cost, Initial Year, by NAICS Code, all Ownerships

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large</th>
<th></th>
<th>Small</th>
<th></th>
<th>Very Small</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hours</td>
<td>Cost</td>
<td>Hours</td>
<td>Cost</td>
<td>Hours</td>
<td>Cost</td>
</tr>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>17.4</td>
<td>$1,560</td>
<td>1.4</td>
<td>$125</td>
<td>0.7</td>
<td>$65</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>20.6</td>
<td>$1,623</td>
<td>1.8</td>
<td>$140</td>
<td>0.7</td>
<td>$54</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>10.4</td>
<td>$692</td>
<td>5.1</td>
<td>$342</td>
<td>1.3</td>
<td>$84</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>2.7</td>
<td>$203</td>
<td>1.6</td>
<td>$116</td>
<td>0.8</td>
<td>$60</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>9.0</td>
<td>$594</td>
<td>3.0</td>
<td>$198</td>
<td>0.5</td>
<td>$36</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>4.3</td>
<td>$281</td>
<td>2.8</td>
<td>$180</td>
<td>0.7</td>
<td>$43</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>98.7</td>
<td>$9,112</td>
<td>15.0</td>
<td>$1,313</td>
<td>0.4</td>
<td>$38</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>192.9</td>
<td>$15,339</td>
<td>67.8</td>
<td>$5,257</td>
<td>2.2</td>
<td>$173</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>28.7</td>
<td>$2,627</td>
<td>10.4</td>
<td>$917</td>
<td>0.4</td>
<td>$37</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>35.3</td>
<td>$2,246</td>
<td>25.6</td>
<td>$1,627</td>
<td>1.3</td>
<td>$85</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual, Developmental Disability</td>
<td>11.9</td>
<td>$442</td>
<td>5.9</td>
<td>$217</td>
<td>2.6</td>
<td>$98</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>17.4</td>
<td>$933</td>
<td>7.2</td>
<td>$382</td>
<td>1.9</td>
<td>$101</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>35.0</td>
<td>$1,811</td>
<td>16.3</td>
<td>$841</td>
<td>1.6</td>
<td>$85</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>14.4</td>
<td>$742</td>
<td>4.4</td>
<td>$228</td>
<td>1.3</td>
<td>$69</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>15.8</td>
<td>$774</td>
<td>5.4</td>
<td>$250</td>
<td>2.0</td>
<td>$93</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>10.5</td>
<td>$513</td>
<td>3.1</td>
<td>$145</td>
<td>1.2</td>
<td>$58</td>
</tr>
<tr>
<td>624120</td>
<td>Services for Elderly and Persons with Disabilities</td>
<td>11.1</td>
<td>$465</td>
<td>2.8</td>
<td>$119</td>
<td>0.4</td>
<td>$19</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>9.1</td>
<td>$431</td>
<td>2.4</td>
<td>$112</td>
<td>0.9</td>
<td>$42</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>1.8</td>
<td>$95</td>
<td>1.0</td>
<td>$53</td>
<td>0.9</td>
<td>$46</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>-</td>
<td>$0</td>
<td>2.4</td>
<td>$126</td>
<td>0.8</td>
<td>$42</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>0.8</td>
<td>$44</td>
<td>1.6</td>
<td>$82</td>
<td>0.6</td>
<td>$33</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>5.4</td>
<td>$281</td>
<td>1.0</td>
<td>$54</td>
<td>0.8</td>
<td>$42</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>7.7</td>
<td>$382</td>
<td>4.2</td>
<td>$208</td>
<td>0.7</td>
<td>$36</td>
</tr>
<tr>
<td></td>
<td>Firefighter-EMT</td>
<td>7.3</td>
<td>$479</td>
<td>2.9</td>
<td>$187</td>
<td>1.0</td>
<td>$67</td>
</tr>
</tbody>
</table>


Table 22 summarizes annually recurring total per-facility hazard assessment costs at the more aggregate healthcare setting level. OSHA invites public comment on the data sources and methodological assumptions underlying the agency’s estimation of costs for paragraph (d) Workplace Violence Hazard Assessment.

Table 15. Total Per-Facility Hazard Assessment Cost, Initial Year, by Setting, all Ownerships
<table>
<thead>
<tr>
<th>Healthcare Setting and Size</th>
<th>Historical Incident Review</th>
<th>Facility Assessment</th>
<th>High-Risk Assessment</th>
<th>Incident Assessments</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioral Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>$445.8</td>
<td>$437.0</td>
<td>$437.0</td>
<td>NA</td>
<td>$1,319.8</td>
</tr>
<tr>
<td>Small</td>
<td>$143.0</td>
<td>$101.2</td>
<td>$101.2</td>
<td>NA</td>
<td>$216.7</td>
</tr>
<tr>
<td>Very Small</td>
<td>$2.7</td>
<td>$31.3</td>
<td>$31.3</td>
<td>NA</td>
<td>$65.2</td>
</tr>
<tr>
<td><strong>Other Hospitals (excluding BH)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>$915.6</td>
<td>$2,828.9</td>
<td>$565.8</td>
<td>$343.4</td>
<td>$4,653.7</td>
</tr>
<tr>
<td>Small</td>
<td>$63.8</td>
<td>$302.7</td>
<td>$60.5</td>
<td>$9.5</td>
<td>$436.6</td>
</tr>
<tr>
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<td>$2.2</td>
<td>$46.9</td>
<td>$9.4</td>
<td>$0.2</td>
<td>$58.7</td>
</tr>
<tr>
<td><strong>Residential Care Facilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>$88.5</td>
<td>$1,054.4</td>
<td>$474.5</td>
<td>$15.0</td>
<td>$1,632.3</td>
</tr>
<tr>
<td>Small</td>
<td>$30.4</td>
<td>$456.8</td>
<td>$205.5</td>
<td>$4.4</td>
<td>$697.2</td>
</tr>
<tr>
<td>Very Small</td>
<td>$6.0</td>
<td>$47.5</td>
<td>$21.4</td>
<td>$0.7</td>
<td>$75.5</td>
</tr>
<tr>
<td><strong>Social Assistance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>$61.2</td>
<td>$273.0</td>
<td>$54.6</td>
<td>$8.9</td>
<td>$397.7</td>
</tr>
<tr>
<td>Small</td>
<td>$7.2</td>
<td>$94.5</td>
<td>$18.9</td>
<td>$0.9</td>
<td>$121.5</td>
</tr>
<tr>
<td>Very Small</td>
<td>$3.7</td>
<td>$33.4</td>
<td>$6.7</td>
<td>$0.4</td>
<td>$44.3</td>
</tr>
<tr>
<td><strong>Home Healthcare Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>$20.5</td>
<td>$527.2</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$547.6</td>
</tr>
<tr>
<td>Small</td>
<td>$5.9</td>
<td>$148.5</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$154.4</td>
</tr>
<tr>
<td>Very Small</td>
<td>$1.1</td>
<td>$25.4</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$26.5</td>
</tr>
<tr>
<td><strong>Emergency Response</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>$22.2</td>
<td>$307.9</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$330.2</td>
</tr>
<tr>
<td>Small</td>
<td>$6.3</td>
<td>$177.8</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$184.0</td>
</tr>
<tr>
<td>Very Small</td>
<td>$2.3</td>
<td>$49.6</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$51.8</td>
</tr>
</tbody>
</table>

Note: Behavioral health settings have a single high-risk area throughout a facility and hence will have no further incident-related hazard assessments, while home healthcare and emergency response are not subject to the requirement of a high-risk hazard assessment and incident-related assessment.


2.4 Control Measures

Paragraph (e) of the regulatory framework, Control Measures, requires employers to implement workplace violence control measures to address workplace violence hazards based on the hazard assessments.

Unit costs for policies and procedures specified under paragraph (e)(1) are included as part of the unit costs for the WVPP pursuant to paragraph (c)(2)(ii), above.

2.4.1 Engineering Control Equipment and Support Staff Unit Costs

Paragraphs (e)(2), (e)(3), and (e)(4) address requirements for controls and are organized into two broad categories: (1) engineering controls and (2) work practice controls. These control requirements are aimed at eliminating or minimizing employee exposure to identified hazards, as
applicable, for a given facility. Several control requirements only apply to high-risk areas as specified in paragraphs (e)(2) and (e)(3). OSHA anticipates that a facility may need to procure specific equipment and/or services in order to achieve compliance with some of the control requirements under paragraphs (e)(1), (e)(2), (e)(3), and (e)(4). Among the specifications that will result in control costs include:

- Designing the physical layout of public areas in the workplace, including waiting rooms and hallways, such that room configuration, furniture dimensions, or other floor arrangements do not impede employee observation of activity within the facility. This requirement includes the removal of sight barriers, the provision of surveillance systems or other sight aids such as mirrors, improved illumination, and the provision of alarm systems or other effective means of communication where the physical layout prevents line of sight;
- Ensuring that employees have unobstructed access to alarms and exit doors as a means to escape violent incidents;
- Ensuring that video surveillance equipment, if any, is operable for the purpose it is intended;
- Removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons in areas where direct patient/client/resident contact/care activities are performed;
- Installing protective barriers between employees and patients/visitors in areas such as admission, triage, and nursing stations;
- Installing, implementing, and maintaining the use of an alarm system, personal panic alarms, or other effective means of emergency communication for employees with direct patient/client or resident care/contact duties;
- Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patient/client/residents are reasonably anticipated to possess unauthorized firearms or other weapons. This could include monitoring and controlling designated public entrances by use of safeguards such as metal detection devices, remote surveillance, alarm systems, or a registration process to limit access to the facility by unauthorized individuals conducted by personnel who are in an appropriately protected work station;
- Maintaining staff designated to immediately respond to workplace violence incidents. To meet this requirement, OSHA estimated the cost for the time spent for staff to respond to incidents. The cost assumes that the staff responding are already employed, and the cost is the time during which they are diverted by responding to incidents;\(^{23}\)

\(^{23}\) OSHA expects that compliance with the draft regulatory text would not lead to the need for additional hires. The agency invites comment from SERs on this preliminary assessment.
• Ensuring employee staffing patterns are sufficient to address workplace violence hazards in high-risk service areas; and,

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

Table 23 presents the set of control equipment included in the analysis along with the unit cost for each type of control equipment, which in some cases vary by the size of the equipment or system. In estimating the total costs for engineering controls, OSHA applied a 20 percent mark-up to the unit cost shown in Table 23 to account for installation, operation, and maintenance of each control unit.

### Table 16. Engineering and Work Practice Control Equipment Unit Costs

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

Note: See Appendix D for sources and details


2.4.2 Facility Control Equipment Requirements

OSHA’s preliminary cost analysis required estimating the number of each type of control equipment that would be necessary for facilities to comply with paragraph (e) of the regulatory...
framework. OSHA recognizes that there is considerable uncertainty in these estimates. Facilities even within the same industry and employee size category can exhibit a high level of variability with respect to the size and layout of their physical facility and surrounding grounds as well as the particular type and cost of controls required to meet facility-specific needs. In addition, the draft rule allows for some discretion by employers in identifying high-risk areas and assessing the optimal set of controls to mitigate risks.

In addition, the rule allows for some discretion by employers in identifying high-risk areas and assessing the optimal set of controls to mitigate risks, further elevating the range of uncertainty in modeling controls. Nevertheless, OSHA judges these estimates useful in illustrating a reasonably representative combination of controls for each setting and size.

The control requirements under paragraph (e) are not mandatory for home healthcare and emergency responder facilities; these facilities are subject to the control requirements specified in Table E-1 and Table E-2 of the draft regulatory framework. The engineering controls in Tables E-1 and E-2 exclusively address communication devices – specifically two-way radios and personal panic devices – and therefore OSHA only estimated costs for these two types of controls for home healthcare and emergency response. Fire fighter-EMTs are assumed to already be provided with all needed communication devices.

Table 24 summarizes OSHA’s approach for estimating the number of each control required, on average, per facility.

Table 17. Methodological Assumptions Underlying Engineering and Work Practice Control Equipment Unit Costs

<table>
<thead>
<tr>
<th>Control Name</th>
<th>Approach for Facility Equipment Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two-way radios</td>
<td>10% of patient care and contact employees per facility</td>
</tr>
<tr>
<td>Personal panic devices</td>
<td>10% of patient care and contact employees per facility</td>
</tr>
<tr>
<td>Paging system</td>
<td>25% of patient care and contact employees per facility</td>
</tr>
<tr>
<td>Electronic access controls</td>
<td>25% of patient care and contact employees per facility</td>
</tr>
<tr>
<td>Enclosed workstations with shatter-resistant glass</td>
<td>An assumption of 2 workstations for large psychiatric hospitals, and scaling other industries and sizes based on their relative size, where size is indicated by the number of high-risk beds per facility (high-risk beds is equal to 100% of total beds for behavioral health and 20% of total beds for other settings, as described in Section 2.3.3).</td>
</tr>
<tr>
<td>Deep service counters</td>
<td>An assumption of 2 counters for large psychiatric hospitals, and scaling other industries and sizes based on their relative size, where size is indicated by the number of high-risk beds per facility.</td>
</tr>
<tr>
<td>Locks on doors</td>
<td>An assumption of 25 locks for large psychiatric hospitals, and scaling other industries and sizes based on their relative size, where size is indicated by the number of high-risk beds per facility.</td>
</tr>
<tr>
<td>CCTV System</td>
<td>An assumption of 1 system for large psychiatric hospitals, and scaling other industries and sizes based on their relative size, where size is indicated by the number of total beds per facility (see Table 16).</td>
</tr>
<tr>
<td>Indoor lights</td>
<td>An assumption of 25 lights for large psychiatric hospitals, and scaling other industries and sizes based on their relative size, where size is indicated by the number of high-risk beds per facility.</td>
</tr>
</tbody>
</table>

25 Control costs for home healthcare and emergency responder facilities will include the costs for communication devices along with other administrative and work practice controls.
<table>
<thead>
<tr>
<th>Equipment Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outdoor lights</td>
<td>An assumption of 15 lights for large psychiatric hospitals, and scaling other industries and sizes based on their relative size, where size is total beds per facility.</td>
</tr>
<tr>
<td>Separate rooms or areas for high-risk patients</td>
<td>5% of the number of high-risk beds per facility</td>
</tr>
<tr>
<td>Opaque glass in patient rooms</td>
<td>10% of the number of high-risk beds per facility</td>
</tr>
<tr>
<td>Circular or curved mirrors</td>
<td>5% of the number of high-risk beds per facility</td>
</tr>
<tr>
<td>Weapon detector, handheld</td>
<td>An assumption of 1 handheld detector for large psychiatric hospitals, and scaling other industries and sizes based on total beds per facility. In addition, OSHA assumes that only a subset of facilities, by setting, will require weapon detectors. These include 100% of behavioral health, 83% of other hospitals, 69% of residential care facilities, and 34% of social assistance facilities.¹</td>
</tr>
</tbody>
</table>

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).


Note: “Beds” here are either actual beds or “bed-equivalents” as discussed in Section 2.3.3.

The number of equipment units assigned to each facility was estimated as the number of units required beyond what facilities might otherwise have in place. For example, OSHA did not specify the total number of lights required for a hospital, but rather the number of additional lights a facility might need to comply with the rule. At the same time, OSHA recognizes that facilities may already have, to varying degrees, sufficient controls in place to address the requirements. OSHA accounts for baseline compliance with respect to these additional controls in the total cost analysis below.

### 2.4.3 Facility Control Equipment Costs

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

### 2.4.4 Incident Response Costs

In addition to control equipment, OSHA estimates the additional labor burden and cost to respond to WPV incidents per paragraph (e). OSHA bases this estimate on the estimated number of WPV incidents per facility (see Table 14) and an assumption that each incident requires on average a total of 0.75 hours of response from patient/client/resident care or contact employees (e.g., 3 people, 15 minutes each, for example). This cost applies to all facilities except for those in the home healthcare and emergency response settings, and is an annually recurring burden and cost. See Table 25 below.

### 2.4.5 Total Per-Facility Control Costs

Table 25 summarizes total per-facility costs under paragraph (e) of the draft regulatory framework, including total equipment costs and labor costs associated with responding to WPV incidents. In all cases, average control costs are much higher than average incident response costs. As noted above, these are costs before taking into account current compliance practices by facilities, which is discussed below.
Table 18. Total Per-Facility Control Costs and Per-Incident Response Team or Individual Responder Costs, all Ownerships ($2019)

| NAICS | NAICS Description | Large | | | Small | | | Very Small | | |
|-------|-------------------|-------|---|---|-------|---|---|---|---|
|       |                   | Equipment | Responder | Equipment | Responder | Equipment | Responder |
| 621112 | Offices of Physicians, Mental Health Specialists | $10,786 | $12.04 | $1,955 | $0.26 | $735 | $0.17 |
| 621330 | Offices of Mental Health Practitioners | $13,938 | $16.86 | $2,089 | $0.89 | $728 | $0.48 |
| 621420 | Outpatient Mental Health and Substance Abuse | $7,431 | $10.71 | $3,651 | $4.86 | $938 | $1.25 |
| 621493 | Freestanding Ambulatory Surgical, Emergency | $2,680 | $8.32 | $1,531 | $4.57 | $740 | $2.10 |
| 621610 | Home Health Care Services | $875 | $0.00 | $294 | $0.00 | $59 | $0.00 |
| 621910 | Ambulance Services | $427 | $0.00 | $273 | $0.00 | $77 | $0.00 |
| 622110 | General Medical and Surgical Hospitals | $100,439 | $1,473.35 | $17,005 | $191.27 | $393 | $3.23 |
| 622210 | Psychiatric and Substance Abuse Hospitals | $69,811 | $5,485.06 | $36,916 | $1,044.43 | $843 | $56.88 |
| 622310 | Specialty Hospitals (excl. Psychiatric, Substance) | $23,392 | $604.30 | $10,701 | $87.68 | $355 | $4.42 |
| 623110 | Nursing Care Facilities (Skilled Nursing Facilities) | $21,794 | $61.40 | $14,773 | $38.97 | $820 | $2.20 |
| 623210 | Residential Intellectual, Developmental Disability | $6,857 | $62.39 | $3,843 | $19.24 | $1,575 | $14.08 |
| 623220 | Residential Mental Health and Substance Abuse | $10,673 | $108.40 | $4,125 | $34.93 | $1,072 | $12.09 |
| 623311 | Continuing Care Retirement Communities | $22,471 | $36.35 | $9,897 | $15.64 | $1,004 | $1.68 |
| 623312 | Assisted Living Facilities for the Elderly | $8,938 | $13.67 | $2,564 | $3.88 | $816 | $1.39 |
| 623990 | Other Residential Care Facilities | $5,249 | $295.81 | $2,635 | $45.19 | $663 | $24.78 |
| 624110 | Child and Youth Services | $6,140 | $103.70 | $2,153 | $10.42 | $846 | $7.12 |
| 624120 | Services for Elderly and Persons with Disabilities | $1,082 | $0.00 | $279 | $0.00 | $51 | $0.00 |
| 624190 | Other Individual and Family Services | $7,049 | $26.15 | $1,829 | $2.05 | $717 | $1.31 |
| 624210 | Community Food Services | $1,440 | $3.13 | $768 | $1.76 | $747 | $0.99 |
| 624221 | Temporary Shelters | $0 | $0.00 | $1,282 | $5.52 | $690 | $2.14 |
| 624229 | Other Community Housing Services | $814 | $5.87 | $972 | $3.57 | $621 | $1.68 |
| 624230 | Emergency and Other Relief Services | $4,285 | $8.92 | $785 | $1.70 | $677 | $0.85 |
| 624310 | Vocational Rehabilitation Services | $5,527 | $34.16 | $3,035 | $12.29 | $540 | $2.34 |
|       | Firefighter-EMTs | $0 | $0.00 | $0 | $0.00 | $0 | $0.00 |

NA = no establishments; Costs shown as $0 indicate no additional compliance action anticipated for the requirement.

2.5 Training

Paragraph (f) of the regulatory framework, Training, requires that employers institute a training program for employees with direct patient/client/resident contact, direct patient/client/resident care, and/or workplace violence incident response duties, along with their supervisory staff. The training program must include the following elements:
• Under paragraph (f)(1), training is required to occur initially, prior to the time of assignment, or when newly assigned to perform duties for which the training is required. In addition, affected employees are required to participate in training at least annually and in some cases more frequently if changes in the job duties or other circumstances require supplemental training;

• Pursuant to paragraphs (f)(3) and (f)(4), the initial training program must contain content that reflects the level of risk to employees and the duties that they are expected to perform. As a result, this preliminary cost analysis included separate training estimates for employees and supervisors with patient care and contact duties;

• Paragraph (f)(5) requires employees within certain occupational categories who are working in high-risk service areas to receive an intermediate level of training. The analysis therefore differentiates training estimates within occupational categories to reflect a mix of high-risk and non-high-risk service area employees; and,

• Under paragraph (f)(6), employees designated to respond to a violent incident and their supervisors must receive an advanced level of instruction with all elements listed in paragraphs (f)(3), (f)(4), and (f)(5). These employees and their supervisors must also be given advanced practical training in de-escalation, chemical and physical restraints (if applicable), and all standard operating procedures that are applicable to the response team.

OSHA’s analysis of training costs accounts for all of the above requirements and specifications. Under paragraph (f)(2), all of the above training is required to be overseen or conducted by a person knowledgeable in the program’s subject matter as it relates to the workplace. The analysis therefore also includes costs associated with the procurement of trainers to conduct the training of applicable employees.

2.5.1 Patient Care, Contact, and Supervisory Employee Training Costs

Employer costs to train employees under the above requirements include the labor cost for employees’ time during the training. The number of employees trained annually for a given facility is based on the number of patient/client/resident care, patient/client/resident contact, and related supervisory employees. The cost for employees’ time participating in the training is driven by the number of hours of training per employee and their respective wage. As noted above, the nature of the required training varies for different groups of trainees. OSHA specifically estimates trainee labor burden – the number of required hours of training per trainee for three categories of employees:

• Non-high-risk service area patient care employees and their supervisors;

• High-risk service area patient care employees and their supervisors;\(^{26}\)

\(^{26}\) Initial training for employees designated to respond to a violent incident and their supervisors, must contain an advanced level of instruction with all elements listed in (f)(3), (f)(4), and (f)(5) and all standard operating
- Patient contact employees and their supervisors.

The number of annual hours of training for each standard and intermediate trainee-category is shown below in Table 26. OSHA specifies training hours for the initial training under the draft regulatory framework, as well as hours for the subsequent annual refresher training. OSHA assumes that standard training in non-high-risk areas is 4 hours for patient care employees and 2 hours for patient contact employees, as well as their respective supervisors. High-risk service area patient care employees and their supervisors get intermediate training and receive twice the hours as those receiving standard training. The refresher training is assumed to be half of the initial training hours.

Table 19. Standard and Intermediate Training Hours, by Employee Category

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Hours-Initial</th>
<th>Hours-Refresher</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-Risk Patient Care Employee and Supervisor</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Non-High-Risk Patient Care Employee and Supervisor</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Patient Contact Employee and Supervisor</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>


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

The total quantity of training hours per facility, by employee type, was then monetized using wages for patient care, patient contact, and supervisor employees. In subsequent years, employees that have already been trained will take refresher training. At the same time, new employees will enter the industry annually who will need initial training. OSHA therefore estimated the cost for employee labor per-facility both initially (year one), and for subsequent years. The cost in subsequent years assumes that 35.5 percent of employees receive the initial training each year, and 64.5 percent receive the refresher training. These percentages were based on an estimated employment turnover rate of 35.5 percent for the healthcare and social assistance industry in 2018 (BLS, 2019c).

2.5.2 Trainer Costs

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

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

---

procedures that are applicable to the response team, or individual responders, as applicable. OSHA therefore assumes that those responding will come from the pool of employees and supervisors with direct patient/client/resident care duties in high-risk service areas that must receive training pursuant to f(5), which encompasses training under f(3) and f(4).
• In most cases, OSHA assumes that facilities will hire outside trainers. The cost per trainer in this case is the time (labor) for the trainer to conduct the training sessions specified above. The quantity of hours required for a trainer to administer the training is based on classroom hours and an estimated class size of 20 employees, and the trainer labor burden was monetized using the training specialist wage for the NAICS code (see Table 6). 27

• OSHA anticipates that some, particularly large, employers may comply with the training requirements by developing in-house trainers certified at a level commensurate with the standards outlined in paragraph (f) of the regulatory framework. These in-house trainers may also be assigned to respond to workplace violence. OSHA assumes that large general, specialty, and psychiatric hospitals will use this approach for procuring trainers and creating incident response teams under the regulatory framework. For this preliminary cost analysis, the agency estimated that two percent of all patient/client/resident care/contact employees in facilities affected by this requirement will receive this training in 20-employee classroom (sizes) and subsequently serve on response teams. The wage estimate for the trainer in this case was based on the direct patient/client/resident care occupation category, rather than that of the outside training specialist. OSHA has also accounted for an additional cost for each trainer, incurred by the employer, to have the employee(s) certified through intensive training.

The unit costs of compliance for employees undergoing intensive training include an annual training course cost, as well as the cost of labor for the time spent during the certification course. Based on consultation and input from subject matter experts, OSHA estimated that in-house trainers on an incident response team will require: 28

  o 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,

  o A one-day recertification program at a cost of $750 per employee, plus 8 hours of class time for current in-house trainers obtaining recertification in subsequent years. OSHA assumed that in-house trainers will be re-certified every three years through the one-day program. After the first year, OSHA assumes that employees previously designated as in-house trainers have an annual turnover rate of 18

27 If the average number of employees being trained per establishment is below 20 in a NAICS size class, then employees per class is adjusted downwards accordingly (increasing trainer costs per employee).

28 Unit cost estimates are based on consideration of a range of similar training programs. For example, CPI: Nonviolent Crisis Intervention Training Program offers programs such as a one-day seminar on de-escalation and prevention ($1,179 per person); a two-day classroom foundation course ($1,799); and, a four-day certification program ($3,249). The Handle With Care Behavior Management System® QBS: Quality Behavioral Solutions to Complex Behavior Problems program includes a three-day certification program at a cost of $1,250 per person, the Quality Behavioral Solutions to Complex Behavior Problems (SAFETY CARE) three-day certification costs $1,325 per person, and the MOAB (Management of Aggressive Behavior) Training Institute offers a three-day course for $1,555 per person.
percent (approximately half of the overall employee turnover rate cited above). Knowing the costs of replacing an in-house trainer, employers are likely to train staff that they believe will be there long term. Therefore, each year approximately 18 percent of in-house trainers are replaced, requiring selected staff to take the full 24-hour course; and 82 percent of in-house trainers take the re-certification every three years or about 27 percent each year.29

For facilities that use in-house trainers, OSHA adjusted the employee-trainee costs from Section 2.5.1 to subtract in-house trainers from the broader pool of trainees. That is, employees designated to become in-house trainers do not also need to be a participant in the training, with its associated cost.

In OSHA’s cost model, other industries and employer sizes were assumed to hire outside trainers. These facilities will not incur the additional cost for developing in-house trainers nor will they have incident response teams. Outside trainer labor was monetized using trainer wages for each industry, while in-house trainers use their current occupation wage.

Using in-house trainers versus outside trainers adds a significant cost for hospitals, the one group that OSHA estimated will use this method.30 The first-year cost for large general hospitals, for example, is $58,000 per facility, on average, with in-house trainers, versus $11,000 for outside trainers. The benefit will be that these in-house trainers could then be designated to respond to workplace violence incidents, as required by the regulatory framework, and may be able to give standard training to fellow employees.

Table 27 summarizes total training costs per employee trained, in year one and subsequent years, including both trainer- and trainee-related costs. Per-employee costs are driven by the above elements of the analysis, including differences in facility size. For example, per-employee costs are higher in the “Offices of Physicians, Mental Health Specialists” industry when compared to “Psychiatric and Substance Abuse Hospitals”, even though both types of facilities are entirely high-risk. The difference on a per-employee basis in this case is mostly due to facilities in the former being very small (most are fewer than 20 employees). This size difference results in the cost of each training class, or session, being divided among a smaller number of people in the “Offices of Physicians, Mental Health Specialists” industry since they generally do not have enough employees to use the entire 20-person capacity per-class.

2.5.3 Total Per-Employee and Facility Training Costs

Table 20. Total Training Cost Per-Employee, all Ownerships ($2019)

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large Facility</th>
<th></th>
<th>Small Facility</th>
<th></th>
<th>Very Small Facility</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>First Year $700</td>
<td>Subsequent Years $472</td>
<td>First Year $753</td>
<td>Subsequent Years $503</td>
<td>First Year $755</td>
<td>Subsequent Years $504</td>
</tr>
</tbody>
</table>

29 This is a simplifying approximation to what would be a complicated temporal sequence of the number being re-certified, which depends on the number of years between re-certification for those trainers who leave over time.  
30 As presented below in Table 33, OSHA preliminarily estimates that current compliance with the training requirements in the regulatory framework range from 50 percent to 65 percent for hospitals. The agency invites comment on that preliminary estimate.
### Table 28: Total Training Costs Per Establishment, by NAICS Code

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large Facility</th>
<th>Small Facility</th>
<th>Very Small Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>First Year</td>
<td>Subsequent Years</td>
<td>First Year</td>
</tr>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>$10,708</td>
<td>$7,218</td>
<td>$2,629</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>$17,435</td>
<td>$11,746</td>
<td>$2,360</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>$9,356</td>
<td>$6,296</td>
<td>$2,199</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>$5,110</td>
<td>$3,440</td>
<td>$2,923</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>$12,169</td>
<td>$8,158</td>
<td>$4,083</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>$5,630</td>
<td>$3,778</td>
<td>$2,131</td>
</tr>
<tr>
<td>622100</td>
<td>General Medical and Surgical Hospitals</td>
<td>$281,693</td>
<td>$163,002</td>
<td>$36,684</td>
</tr>
</tbody>
</table>

NA = no establishments

Table 28 summarizes total training costs per facility, in year one and subsequent years, including both trainer- and trainee-related costs.

### Table 21. Total Per-Facility Training Cost, all Ownerships ($2019)

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large Facility</th>
<th>Small Facility</th>
<th>Very Small Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>First Year</td>
<td>Subsequent Years</td>
<td>First Year</td>
</tr>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
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<td>$2,360</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>$9,356</td>
<td>$6,296</td>
<td>$2,199</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>$5,110</td>
<td>$3,440</td>
<td>$2,923</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
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<td>$8,158</td>
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</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>$5,630</td>
<td>$3,778</td>
<td>$2,131</td>
</tr>
<tr>
<td>622100</td>
<td>General Medical and Surgical Hospitals</td>
<td>$281,693</td>
<td>$163,002</td>
<td>$36,684</td>
</tr>
</tbody>
</table>
### Table: NAICS and Facility Costs

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large Facility</th>
<th></th>
<th></th>
<th>Small Facility</th>
<th></th>
<th></th>
<th>Very Small Facility</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>First Year</td>
<td>Subsequent Years</td>
<td>First Year</td>
<td>Subsequent Years</td>
<td>First Year</td>
<td>Subsequent Years</td>
<td>First Year</td>
<td>Subsequent Years</td>
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<td>Psychiatric and Substance Abuse Hospitals</td>
<td>$46,585</td>
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<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
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<td>$20,222</td>
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<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>$18,762</td>
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<td>$672</td>
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<td>Residential Intellectual, Developmental Disability</td>
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<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>$4,344</td>
<td>$2,917</td>
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<td></td>
<td>$937</td>
<td>$616</td>
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<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>$4,327</td>
<td>$2,904</td>
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<td>$1,614</td>
<td>$1,076</td>
<td></td>
<td>$798</td>
<td>$524</td>
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<td>$10,920</td>
<td>$7,327</td>
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<td>$2,813</td>
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<td></td>
<td>$655</td>
<td>$428</td>
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<td>Other Individual and Family Services</td>
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<td></td>
<td>$1,392</td>
<td>$926</td>
<td></td>
<td>$698</td>
<td>$456</td>
<td></td>
</tr>
<tr>
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<td>Community Food Services</td>
<td>$1,271</td>
<td>$846</td>
<td></td>
<td>$790</td>
<td>$520</td>
<td></td>
<td>$774</td>
<td>$509</td>
<td></td>
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<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>$0</td>
<td>$0</td>
<td></td>
<td>$1,628</td>
<td>$1,087</td>
<td></td>
<td>$743</td>
<td>$488</td>
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</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
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<td>$776</td>
<td></td>
<td>$1,115</td>
<td>$740</td>
<td></td>
<td>$626</td>
<td>$409</td>
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<td>624230</td>
<td>Emergency and Other Relief Services</td>
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<td>$2,333</td>
<td></td>
<td>$802</td>
<td>$528</td>
<td></td>
<td>$715</td>
<td>$469</td>
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<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
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<td>$2,483</td>
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<td>$2,151</td>
<td>$1,444</td>
<td></td>
<td>$522</td>
<td>$340</td>
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<td></td>
<td>Firefighter-EMT</td>
<td>$19,538</td>
<td>$13,105</td>
<td></td>
<td>$3,169</td>
<td>$2,126</td>
<td></td>
<td>$1,432</td>
<td>$952</td>
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</tr>
</tbody>
</table>


2.6 Violent Incident Investigation and Recordkeeping

Paragraph (g) of the regulatory framework has several requirements the employer must implement regarding violent incident reporting and maintenance of related records. The requirements costing here are organized into three categories:

- **Violent incident investigation.** Paragraph (g)(2) requires that employers establish procedures to investigate the circumstances of each reported WPV incident within 24 hours of notification of the incident occurring and document the significant contributing factors, recommendations, and any corrective measures that will be taken to prevent similar incidents.

- **Violent incident log.** Paragraphs (g)(1) and (g)(4) require that employers implement and maintain a violent incident reporting system and establish and maintain records of each violent incident that occurs in the workplace. Employers are required to solicit input from the employee(s) who experienced or observed the workplace violence. The violent incident log must include key information such as, but not limited to: the nature and extent of the employee’s injuries; the date, time, and location of the incident; the job titles

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31 Costs for investigation procedures specified under paragraph (g)(1) are included as part of the costs for the WVPP pursuant to paragraph (c). Incident-related hazard assessment costs specified under paragraph (g)(3) are accounted for in the costs for paragraph (d), hazard assessments.
of involved employee(s); a classification of circumstances at the time of the incident; and a classification of the person who committed the violence (e.g., patient, coworker, stranger, etc.).

- **Retention of records.** Paragraph (h) requires that employers maintain records from WVPP development, hazard assessment and control processes, and incident investigations for at least three years. In addition, training records are to be maintained for at least one year.

The labor burden and cost per facility presented here will be constant each year, assuming the same number of incidents occur each year. Hence, recurring costs for these elements will be overestimated to the extent the implementation of the regulatory framework is effective and decreases the number of WPV incidents.

2.6.1 Violent Incident Investigation Costs

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

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

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

Table 29 presents OSHA’s estimate of the per-incident labor burden, by incident type and labor category, for incident investigations.

<table>
<thead>
<tr>
<th>Type of WPV Incident and Labor Category</th>
<th>Investigation Hours (per Incident)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lost Work Incidents</strong></td>
<td></td>
</tr>
<tr>
<td>Patient Care/Contact Employee</td>
<td>2</td>
</tr>
<tr>
<td>Management/Supervisor Employee</td>
<td>4</td>
</tr>
<tr>
<td><strong>Non-Lost Work Incidents</strong></td>
<td></td>
</tr>
<tr>
<td>Patient Care/Contact Employee</td>
<td>1.5</td>
</tr>
<tr>
<td>Management/Supervisor Employee</td>
<td>3</td>
</tr>
<tr>
<td><strong>Other Physical</strong></td>
<td></td>
</tr>
<tr>
<td>Patient Care/Contact Employee</td>
<td>1</td>
</tr>
<tr>
<td>Management/Supervisor Employee</td>
<td>2</td>
</tr>
<tr>
<td><strong>Threats</strong></td>
<td></td>
</tr>
<tr>
<td>Patient Care/Contact Employee</td>
<td>0.5</td>
</tr>
<tr>
<td>Management/Supervisor Employee</td>
<td>1</td>
</tr>
</tbody>
</table>

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

Table 30 summarizes per-facility costs for investigating each workplace violence incident.

Table 23. Incident Investigation Burden and Cost per Facility, all Ownerships

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large</th>
<th></th>
<th>Small</th>
<th></th>
<th>Very Small</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hours</td>
<td>Cost</td>
<td>Hours</td>
<td>Cost</td>
<td>Hours</td>
<td>Cost</td>
</tr>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
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<td>$50</td>
<td>0.0</td>
<td>$1</td>
<td>0.0</td>
<td>$1</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
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<td>$5</td>
<td>0.0</td>
<td>$3</td>
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<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
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<td>$64</td>
<td>0.5</td>
<td>$29</td>
<td>0.1</td>
<td>$7</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>0.6</td>
<td>$44</td>
<td>0.3</td>
<td>$24</td>
<td>0.2</td>
<td>$11</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>0.8</td>
<td>0.8</td>
<td>0.3</td>
<td>$0</td>
<td>0.0</td>
<td>$0</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>0.8</td>
<td>0.8</td>
<td>0.5</td>
<td>$0</td>
<td>0.1</td>
<td>$0</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
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<td>13.9</td>
<td>$1,133</td>
<td>0.2</td>
<td>$19</td>
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<td>92.2</td>
<td>$6,620</td>
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<td>$360</td>
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<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
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<td>$567</td>
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<td>$29</td>
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<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
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<td>4.8</td>
<td>$286</td>
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<td>$16</td>
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<tr>
<td>623210</td>
<td>Residential Intellectual, Developmental Disability</td>
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<td>3.3</td>
<td>$115</td>
<td>2.4</td>
<td>$84</td>
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<tr>
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<td>Residential Mental Health and Substance Abuse</td>
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<td>4.6</td>
<td>$229</td>
<td>1.6</td>
<td>$79</td>
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<td>$13</td>
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<td>$29</td>
<td>0.2</td>
<td>$11</td>
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<td>Other Residential Care Facilities</td>
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<td>$155</td>
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<td>Child and Youth Services</td>
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<td>1.7</td>
<td>$2</td>
<td>1.1</td>
<td>$1</td>
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<td>Services for Elderly and Persons with Disabilities</td>
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<td>1.0</td>
<td>$1</td>
<td>0.2</td>
<td>$0</td>
</tr>
<tr>
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<td>Other Individual and Family Services</td>
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<td>$4</td>
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<td>$0</td>
<td>0.2</td>
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</tr>
<tr>
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<td>0.3</td>
<td>$0</td>
</tr>
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<td>$0</td>
<td>0.2</td>
<td>$0</td>
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<tr>
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<td>$0</td>
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<td>$0</td>
</tr>
<tr>
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</table>


2.6.2 Violent Incident Log and Record Retention Costs

As with investigations, per-incident and facility costs for creation of the incident log are a function of the estimated number of incidents per facility, by incident type, and an estimated labor burden per type of incident. OSHA estimates that reportable lost-work and non-lost-work incidents require 10 minutes per incident to create a log entry, while less severe incidents (other physical and threat incidents) require 5 minutes. A log entry is assumed to be created by a manager and hence the labor burden was monetized using manager wage rates. OSHA invites comments from SERs on OSHA’s preliminary unit time estimates and, broadly, on the
observations by SERs on the practice of logging and retaining reportable WPV incidents.

For employer maintenance of records for all hazard assessment and incident investigations, OSHA estimated a per-record labor burden of 5 minutes (0.08 hours) per year. Estimated annual labor burden per facility for record retention was monetized using clerical wages.

Table 31 summarizes facility costs for recordkeeping (i.e., incident log creation and records retention.)

**Table 24. Recordkeeping Burden and Cost per Facility, all Ownerships**

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Large</th>
<th></th>
<th>Small</th>
<th></th>
<th>Very Small</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hours</td>
<td>Cost</td>
<td>Hours</td>
<td>Cost</td>
<td>Hours</td>
<td>Cost</td>
<td></td>
</tr>
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<td>$1.08</td>
<td>0.00</td>
<td>$0.02</td>
<td>0.00</td>
<td>$0.02</td>
</tr>
<tr>
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<td>Offices of Mental Health Practitioners</td>
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<td>0.00*</td>
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<td>Outpatient Mental Health and Substance Abuse</td>
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<td>0.01</td>
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<td>$0.05</td>
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<td>$92.14</td>
<td>0.45</td>
<td>$13.37</td>
<td>0.02</td>
<td>$0.67</td>
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<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
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<td>0.32</td>
<td>$9.28</td>
<td>0.02</td>
<td>$0.52</td>
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<tr>
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<td>$12.54</td>
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<td>$6.88</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>16.61</td>
<td>$16.61</td>
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<td>$1.67</td>
<td>1.14</td>
<td>$1.14</td>
</tr>
<tr>
<td>624120</td>
<td>Services for Elderly and Persons with Disabilities</td>
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<td>$4.76</td>
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<td>$0.98</td>
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<td>Community Food Services</td>
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<td>$0.43</td>
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<td>$0.13</td>
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<td>624221</td>
<td>Temporary Shelters</td>
<td>NA</td>
<td>NA</td>
<td>0.76</td>
<td>$0.76</td>
<td>0.29</td>
<td>$0.29</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>0.80</td>
<td>$0.80</td>
<td>0.49</td>
<td>$0.49</td>
<td>0.23</td>
<td>$0.23</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>1.22</td>
<td>$1.22</td>
<td>0.23</td>
<td>$0.23</td>
<td>0.12</td>
<td>$0.12</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>5.30</td>
<td>$5.30</td>
<td>1.91</td>
<td>$1.91</td>
<td>0.36</td>
<td>$0.36</td>
</tr>
<tr>
<td></td>
<td>Firefighter-EMTs</td>
<td>0.29</td>
<td>$8.15</td>
<td>0.03</td>
<td>$0.84</td>
<td>0.01</td>
<td>$0.42</td>
</tr>
</tbody>
</table>


* = appears as zero due to rounding.
3. Total Costs

3.1 Introduction

This chapter brings together information from the industry profile and unit cost analysis to estimate the industry-level total cost of compliance with the regulatory framework. Per-establishment unit costs were estimated at the industry level based on the total number of establishments by industry, ownership, and establishment size. The total cost analysis also accounts for baseline compliance for each requirement, and the time profile of one-time and recurring costs span a ten-year period. Here, recurring costs that are related to the number of incidents do not change over time and thus are an over-estimate because the regulatory framework is expected to result in a decrease in the number of incidents.

All costs presented here are annualized. Annualized costs take a standard 10-year horizon of initial one-time costs and nine years of annual recurring costs and reflect a constant annual equivalent for each of the ten years. Analogous to paying off a loan with constant yearly payments worth the present value of the ten years’ worth of costs, annualized cost depends positively on the discount rate used. Total and per-facility annualized costs were estimated using both a three-percent and seven-percent discount rate. Table 32 summarizes the annualized costs of the rule by paragraph and presents an estimated total cost of $1.22 billion per year using a three percent discount rate. Not shown in Table 32 are annualized costs at a seven-percent discount rate: $1.25 billion. Training is by far the largest cost element, making up 75 percent of the total cost.

Table 25. Total Annualized Costs

<table>
<thead>
<tr>
<th>Draft Rule Provision</th>
<th>Total Annualized Cost, millions, $2019, 3% discount rate*</th>
<th>Percentage of Total Cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paragraph (c) – Workplace Violence Prevention Plan</td>
<td>$65.1</td>
<td>5.4%</td>
</tr>
<tr>
<td>Paragraph (d) – Workplace Hazard Assessment</td>
<td>$63.6</td>
<td>5.2%</td>
</tr>
<tr>
<td>Paragraph (e) – Controls</td>
<td>$104.8</td>
<td>8.6%</td>
</tr>
<tr>
<td>Paragraph (f) – Training</td>
<td>$908.8</td>
<td>74.7%</td>
</tr>
<tr>
<td>Paragraph (g) – Violent Incident Reporting</td>
<td>$73.5</td>
<td>6.0%</td>
</tr>
<tr>
<td>Total</td>
<td>$1,215.9</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Due to rounding, figures in this column may not sum to the total shown.

3.2 Baseline

Total costs of the proposed regulatory framework must take into account a compliance baseline to capture current practices among affected facilities for each of the potential regulatory provisions. Practices already in place are not new costs in relation to implementation of the potential proposed rule and therefore would need to be deducted to estimate the cost of the potential proposed rule. OSHA consulted healthcare facility management and security experts in order to specify baseline compliance (Abt, 2020). Table 33 presents the estimated degree of compliance with a given requirement across the overall population of facilities in a given
healthcare setting, where percentages reflect the reality that some facilities may be in compliance with only a subset of the section’s requirements. For example, even though most employers likely conducted some sort of post-incident investigation, many might not have focused on the specific information required by the draft rule or involved employees as required by the draft rule. Those employers would not be considered in compliance for baseline purposes.

<table>
<thead>
<tr>
<th>Potential Rule Provision</th>
<th>Behavioral Health</th>
<th>Other Hospitals</th>
<th>Residential Care</th>
<th>Home Healthcare</th>
<th>Social Assistance</th>
<th>Emergency Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paragraph (c), WVPP</td>
<td>45%</td>
<td>28%</td>
<td>41%</td>
<td>30%</td>
<td>20%</td>
<td>36%</td>
</tr>
<tr>
<td>Paragraph (d), Hazard Assessment</td>
<td>30%</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Paragraph (e) Controls</td>
<td>48%</td>
<td>66%</td>
<td>37%</td>
<td>41%</td>
<td>12%</td>
<td>48%</td>
</tr>
<tr>
<td>Paragraph (f) Training</td>
<td>65%</td>
<td>50%</td>
<td>35%</td>
<td>25%</td>
<td>50%</td>
<td>44%</td>
</tr>
<tr>
<td>Paragraph (g)(2) &amp; (g)(3) Investigation</td>
<td>50%</td>
<td>50%</td>
<td>35%</td>
<td>25%</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Paragraph (g)(4), Recordkeeping</td>
<td>60%</td>
<td>75%</td>
<td>50%</td>
<td>50%</td>
<td>10%</td>
<td>59%</td>
</tr>
</tbody>
</table>


3.3 Workplace Violence Prevention Program (WVPP)

Incremental, annualized costs for WVPP, paragraph (c) of the potential rule, are estimated based on (1) facility-level one-time and annual unit costs absent compliance (summarized in Table 34), (2) the number of affected establishments, and (3) the extent of baseline compliance with the potential rule’s requirements. Table 34 presents the annualized costs for the potential rule’s WVPP requirements, by NAICS industry, aggregated across all facility size and ownership categories. Total annualized costs for this requirement are estimated to be approximately $65.1 million per year.

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Number of Establishments</th>
<th>Total Annualized Cost (3%)</th>
<th>Annualized Cost per Establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>10,817</td>
<td>$1,768,738</td>
<td>$164</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>25,370</td>
<td>$4,516,032</td>
<td>$178</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>11,969</td>
<td>$5,561,330</td>
<td>$465</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>7,661</td>
<td>$300,456</td>
<td>$39</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>33,581</td>
<td>$5,886,979</td>
<td>$175</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>5,672</td>
<td>$638,587</td>
<td>$113</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>5,285</td>
<td>$7,273,456</td>
<td>$1,376</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>1,442</td>
<td>$1,637,391</td>
<td>$1,136</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>920</td>
<td>$382,900</td>
<td>$416</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>17,138</td>
<td>$10,946,294</td>
<td>$639</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual, Developmental Disability</td>
<td>35,218</td>
<td>$8,454,404</td>
<td>$240</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>8,084</td>
<td>$3,962,507</td>
<td>$490</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>5,570</td>
<td>$2,148,146</td>
<td>$386</td>
</tr>
</tbody>
</table>
### Table 35. Annualized Compliance Costs for Hazard Assessments, all Ownerships ($2019)

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Number of Establishments</th>
<th>Total Annualized Cost (3%)*</th>
<th>Annualized Cost per Establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>10,817</td>
<td>$528,496</td>
<td>$49</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>25,370</td>
<td>$1,391,004</td>
<td>$55</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>11,969</td>
<td>$1,995,413</td>
<td>$167</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>7,661</td>
<td>$399,394</td>
<td>$52</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>33,581</td>
<td>$4,464,891</td>
<td>$133</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>5,672</td>
<td>$475,073</td>
<td>$84</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>5,285</td>
<td>$12,965,947</td>
<td>$2,452</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>1,442</td>
<td>$7,852,151</td>
<td>$5,446</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>920</td>
<td>$748,170</td>
<td>$813</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>17,138</td>
<td>$12,845,214</td>
<td>$750</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual, Developmental Disability</td>
<td>35,218</td>
<td>$4,474,628</td>
<td>$127</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>8,084</td>
<td>$1,668,249</td>
<td>$206</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>5,570</td>
<td>$2,490,234</td>
<td>$447</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>20,052</td>
<td>$2,746,497</td>
<td>$137</td>
</tr>
</tbody>
</table>


*Due to rounding, figures in this column may not sum to the total shown.

### 3.4 Workplace Hazard Assessment

Using the three-step methodology described immediately above for aggregating costs of workplace violence prevention programs, OSHA combined the facility-level costs of compliance for hazard assessments summarized in Table 21 with the number of affected establishments and estimated baseline compliance to calculate total costs for workplace hazard assessments. Table 35 presents the annualized costs of compliance for the potential rule’s hazard assessment requirements, by industry, for all sizes and ownerships. Annualized costs for hazard assessments are estimated to total approximately $63.6 million per year.
## 3.5 Controls

Table 36 summarizes the annualized costs of compliance for the potential rule’s control requirements, which includes costs both for implementation of controls and for staff time during incident response, by industry, for all sizes and ownerships. Total annualized costs for controls are estimated to be approximately $104.8 million per year.

### Table 29. Annualized Compliance Costs for Controls, all Ownerships ($2019)

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Number of Establishments</th>
<th>Total Annualized Cost (3%)*</th>
<th>Annualized Cost per Establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>10,817</td>
<td>$1,252,689</td>
<td>$116</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>25,370</td>
<td>$3,146,642</td>
<td>$124</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>11,969</td>
<td>$3,271,226</td>
<td>$273</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>7,661</td>
<td>$630,395</td>
<td>$82</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>33,581</td>
<td>$1,002,596</td>
<td>$30</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>5,672</td>
<td>$109,874</td>
<td>$19</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>5,285</td>
<td>$17,842,473</td>
<td>$3,376</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>1,442</td>
<td>$8,918,334</td>
<td>$6,186</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>920</td>
<td>$919,362</td>
<td>$999</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>17,138</td>
<td>$22,684,658</td>
<td>$1,324</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual, Developmental Disability</td>
<td>35,218</td>
<td>$11,726,934</td>
<td>$333</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>8,084</td>
<td>$3,020,326</td>
<td>$374</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>5,570</td>
<td>$5,594,768</td>
<td>$1,004</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>20,052</td>
<td>$5,951,182</td>
<td>$297</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>5,371</td>
<td>$1,515,228</td>
<td>$282</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>12,278</td>
<td>$3,695,758</td>
<td>$301</td>
</tr>
</tbody>
</table>


*Due to rounding, figures in this column may not sum to the total shown.*
3.6 Training

For this PIRFA, the number of employees in each NAICS industry and size is held constant over time. In year one of the analysis, costs are incurred based on initial training unit costs. In subsequent years of the analysis, the total cost reflects a mix of employees participating in initial and refresher training, based on employment turnover, as described in 2.5.1.

Table 37 summarizes the annualized costs of compliance for the potential rule’s training requirements, by industry, for all sizes and ownerships. Total annualized costs for training are estimated to be approximately $909 million per year.

### Table 30. Annualized Compliance Costs for Training, all Ownerships ($2019)

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Number of Establishments</th>
<th>Total Annualized Cost (3%)*</th>
<th>Annualized Cost per Establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>10,817</td>
<td>$7,168,000</td>
<td>$663</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>25,370</td>
<td>$14,721,411</td>
<td>$580</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>11,969</td>
<td>$18,305,809</td>
<td>$1,529</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>7,661</td>
<td>$10,647,296</td>
<td>$1,390</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>5,672</td>
<td>$8,917,289</td>
<td>$1,572</td>
</tr>
<tr>
<td>621610</td>
<td>Ambulance Services</td>
<td>5,672</td>
<td>$8,917,289</td>
<td>$1,572</td>
</tr>
<tr>
<td>62210</td>
<td>General Medical and Surgical Hospitals</td>
<td>5,285</td>
<td>$357,400,337</td>
<td>$67,624</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>1,442</td>
<td>$15,628,513</td>
<td>$10,840</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>920</td>
<td>$15,224,073</td>
<td>$16,546</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>17,138</td>
<td>$126,541,831</td>
<td>$7,384</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual, Developmental Disability</td>
<td>35,218</td>
<td>$28,729,703</td>
<td>$816</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>8,084</td>
<td>$11,148,608</td>
<td>$1,379</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>5,750</td>
<td>$25,366,564</td>
<td>$4,554</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>20,052</td>
<td>$25,602,648</td>
<td>$1,277</td>
</tr>
<tr>
<td>629990</td>
<td>Other Residential Care Facilities</td>
<td>5,371</td>
<td>$6,772,222</td>
<td>$1,261</td>
</tr>
</tbody>
</table>

*Due to rounding, figures in this column may not sum to the total shown.
### 3.7 Violent Incident Investigation and Recordkeeping

Incremental, annualized compliance costs for violent incident investigation are based on annual per-facility incident investigation costs, previously summarized in Table 30. This PIRFA assumes a constant number of incidents per year, based on the analysis presented in Appendix C. Incremental costs for recordkeeping are similarly based on per-facility recordkeeping costs, summarized in Table 31.

In both cases, per-facility costs were scaled to the industry level based on the number of establishments, and adjusted to reflect the degree of baseline compliance specified in Table 33. Recordkeeping costs reflect the annual monetized burden of establishing and maintaining a log of violent incidents.

Table 38 summarizes the annualized costs of compliance for the potential rule’s investigation and recordkeeping requirements, by NAICS industry, for all sizes and ownerships. Total annualized costs for training are estimated to be approximately $73.5 million per year.

---

**Table 31. Annualized Compliance Costs for Investigation and Recordkeeping, all Ownerships ($2019)**

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Number of Establishments</th>
<th>Total Annualized Cost (3%)*</th>
<th>Annualized Cost per Establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>10,817</td>
<td>$6,042</td>
<td>$0.6</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>25,370</td>
<td>$62,312</td>
<td>$2</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>11,969</td>
<td>$249,749</td>
<td>$21</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>7,661</td>
<td>$136,148</td>
<td>$18</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>33,581</td>
<td>$639,341</td>
<td>$19</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>5,672</td>
<td>$133,562</td>
<td>$24</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>5,285</td>
<td>$25,021,203</td>
<td>$4,734</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>1,442</td>
<td>$25,599,024</td>
<td>$17,755</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>920</td>
<td>$2,193,155</td>
<td>$2,384</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>17,138</td>
<td>$4,057,507</td>
<td>$237</td>
</tr>
</tbody>
</table>

*Source: OSHA, 2023.*

*Due to rounding, figures in this column may not sum to the total shown.
Table 32. Summary of Total Annualized Costs for the Draft Rule, by NAICS ($2019)

<table>
<thead>
<tr>
<th>Setting and NAICS, AllOwnerships</th>
<th>NAICS Description</th>
<th>Number of Establishments</th>
<th>Total Annualized Cost(3%)*</th>
<th>Annualized Cost per Establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioral Health</strong></td>
<td>621112 Offices of Physicians, Mental Health Specialists</td>
<td>10,817</td>
<td>$10,723,964</td>
<td>$991</td>
</tr>
<tr>
<td>621330 Offices of Mental Health Practitioners (except Physicians)</td>
<td>25,370</td>
<td>$23,837,401</td>
<td>$940</td>
<td></td>
</tr>
<tr>
<td>621420 Outpatient Mental Health and Substance Abuse Centers</td>
<td>11,969</td>
<td>$29,383,527</td>
<td>$2,455</td>
<td></td>
</tr>
<tr>
<td>622210 Psychiatric and Substance Abuse Hospitals</td>
<td>1,442</td>
<td>$59,635,413</td>
<td>$41,362</td>
<td></td>
</tr>
<tr>
<td>623210 Residential Intellectual and Developmental Disability</td>
<td>35,218</td>
<td>$58,244,372</td>
<td>$1,654</td>
<td></td>
</tr>
<tr>
<td>623311 Continuing Care Retirement Communities</td>
<td>5,570</td>
<td>$593,569</td>
<td>$107</td>
<td></td>
</tr>
<tr>
<td>623312 Assisted Living Facilities for the Elderly</td>
<td>20,052</td>
<td>$623,251</td>
<td>$31</td>
<td></td>
</tr>
<tr>
<td>623990 Other Residential Care Facilities</td>
<td>5,371</td>
<td>$2,043,314</td>
<td>$380</td>
<td></td>
</tr>
<tr>
<td>623220 Residential Mental Health and Substance Abuse Facilities</td>
<td>8,084</td>
<td>$1,617,682</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>624110 Child and Youth Services</td>
<td>12,278</td>
<td>$1,849,267</td>
<td>$151</td>
<td></td>
</tr>
<tr>
<td>624120 Services for Elderly and Persons with Disabilities</td>
<td>35,075</td>
<td>$1,553,607</td>
<td>$44</td>
<td></td>
</tr>
<tr>
<td>624190 Other Individual and Family Services</td>
<td>29,937</td>
<td>$871,141</td>
<td>$29</td>
<td></td>
</tr>
<tr>
<td>624210 Community Food Services</td>
<td>4,790</td>
<td>$53,159</td>
<td>$11</td>
<td></td>
</tr>
<tr>
<td>624221 Temporary Shelters</td>
<td>4,287</td>
<td>$132,477</td>
<td>$31</td>
<td></td>
</tr>
<tr>
<td>624229 Other Community Housing Services</td>
<td>4,696</td>
<td>$94,293</td>
<td>$20</td>
<td></td>
</tr>
<tr>
<td>624230 Emergency and Other Relief Services</td>
<td>1,112</td>
<td>$31,280</td>
<td>$28</td>
<td></td>
</tr>
<tr>
<td>624310 Vocational Rehabilitation Services</td>
<td>8,011</td>
<td>$914,620</td>
<td>$114</td>
<td></td>
</tr>
<tr>
<td>624320 Firefighter EMTs</td>
<td>6,110</td>
<td>$215,546</td>
<td>$35</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>300,447</strong></td>
<td><strong>$73,549,924</strong></td>
<td><strong>Avg.: $245</strong></td>
<td></td>
</tr>
</tbody>
</table>


*Due to rounding, figures in this column may not sum to the total shown.

3.8 Summary of Total Costs

Table 39 presents the draft regulatory framework’s total cost by NAICS code. These costs include all aspects of the rule and all facilities. Total cost is estimated to be $1.22 billion per year, at a 3 percent discount rate, for the 300,447 affected establishments. Total cost is $1.25 billion per year with a seven percent discount rate.
<table>
<thead>
<tr>
<th>Setting and NAICS, All Ownerships</th>
<th>NAICS Description</th>
<th>Number of Establishments</th>
<th>Annualized Cost, All Rule Provisions (3% rate)*</th>
<th>Annualized Cost per Establishment, (3% rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>622110 622310</td>
<td>General Medical and Surgical Hospitals</td>
<td>5,285</td>
<td>$420,498,417</td>
<td>$79,563</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>Specialty (except Psych and Substance) Hospitals</td>
<td>920</td>
<td>$19,467,660</td>
<td>$21,157</td>
</tr>
<tr>
<td>623311 623312 623990 623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>17,138</td>
<td>$177,075,504</td>
<td>$10,332</td>
</tr>
<tr>
<td>623311 623310 623312 623990</td>
<td>Continuing Care Retirement Communities</td>
<td>5,570</td>
<td>$36,193,282</td>
<td>$6,498</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>20,052</td>
<td>$37,309,603</td>
<td>$1,861</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>Other Residential Care Facilities</td>
<td>5,371</td>
<td>$11,515,025</td>
<td>$2,144</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>Child and Youth Services</td>
<td>12,278</td>
<td>$16,723,697</td>
<td>$1,362</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>Other Individual and Family Services</td>
<td>29,937</td>
<td>$32,064,808</td>
<td>$1,071</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>Community Food Services</td>
<td>4,790</td>
<td>$2,223,941</td>
<td>$464</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>Temporary Shelters</td>
<td>4,287</td>
<td>$3,696,492</td>
<td>$862</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>Other Community Housing Services</td>
<td>4,696</td>
<td>$2,780,579</td>
<td>$592</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>Emergency and Other Relief Services</td>
<td>1,112</td>
<td>$1,279,874</td>
<td>$1,150</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>Vocational Rehabilitation Services</td>
<td>8,011</td>
<td>$13,590,536</td>
<td>$1,696</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>Home Health Care Services</td>
<td>33,581</td>
<td>$121,502,711</td>
<td>$3,618</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>35,075</td>
<td>$81,254,196</td>
<td>$2,317</td>
</tr>
<tr>
<td>Emergency Response</td>
<td>Emergency Response</td>
<td>11,782</td>
<td>$23,320,923</td>
<td>$1,979</td>
</tr>
<tr>
<td>Emergency Response</td>
<td>Ambulance Services</td>
<td>5,672</td>
<td>$10,274,385</td>
<td>$1,811</td>
</tr>
<tr>
<td>Emergency Response</td>
<td>Firefighter-EMTs</td>
<td>6,110</td>
<td>$13,046,539</td>
<td>$2,135</td>
</tr>
<tr>
<td>All Entities</td>
<td>All Entities</td>
<td>300,447</td>
<td>$1,215,852,985</td>
<td>$4,047</td>
</tr>
</tbody>
</table>


*Due to rounding, figures in this column may not sum to the total shown.
4. Economic Feasibility and Small Business Impacts

The preceding discussion focused on the total costs of the draft regulatory framework for affected industries. To provide an estimate of the economic significance of the impacts of these costs, OSHA examined the annualized costs of the draft standard versus revenues and profits, for each affected industry. OSHA uses a minimum threshold level of annualized compliance costs equal to one percent of annual revenues—and, secondarily, annualized compliance costs equal to ten percent of annual profits—below which the agency typically concludes, in the absence of special circumstances, that the costs are unlikely to threaten the feasibility and survival of the industry as a whole. The agency then repeats this analysis for small entities and very small entities. Here the agency typically uses the same threshold of one percent of revenues, but a stricter threshold of ten percent of profits, to investigate whether a significant number of smaller entities might be economically threatened and the overall competitive structure of an industry might be altered for the worse.

These comparisons were made based on each entity’s NAICS code, ownership, and size classification. Average revenue was estimated using total receipts and total entities from CBP 2017 data, as described in Section 1.3. Average profits were derived by applying a NAICS-specific profit rate to each average revenue estimate. The profit rates were calculated using 2004 – 2013 data from the 2013 Corporation Source Book, the most recent data available (Internal Revenue Service, 2019). All values were adjusted to 2019 dollars using the GDP implicit price deflator from BEA (BEA 2019). OSHA requests feedback from SERs regarding whether the profit-rate screen remains a useful screen for this rulemaking and whether an alternative screen would be more appropriate for employers potentially affected by this draft rule.

The IRS data are limited in the detail of their industry breakdown, and so each six-digit NAICS code was mapped to one of three possible three-digit NAICS code values from the IRS data. These data include the total receipts and net income for available industry codes. Profit rates were calculated by dividing the net income by total receipts for each industry sector, and averaged over the 2004 through 2013 time span to calculate an average profit rate to apply to the average revenue figures. Table 40 shows these rates as well as the mapping of profit rates to healthcare settings, and hence six-digit NAICS code, used in the analysis.

Table 40. Profit Rates, by NAICS (percent of total revenue)

<table>
<thead>
<tr>
<th>3-Digit NAICS</th>
<th>NAICS Description</th>
<th>Map to Healthcare Setting</th>
<th>Profit Rate (% of revenue)</th>
</tr>
</thead>
<tbody>
<tr>
<td>621</td>
<td>Offices of Practitioners and Outpatient Care Centers</td>
<td>Behavioral Health</td>
<td>6.6%</td>
</tr>
<tr>
<td>625</td>
<td>Misc. Health Care and Social Assistance</td>
<td>Home Health, Social Assistance, Emergency Responders</td>
<td>6.4%</td>
</tr>
<tr>
<td>626</td>
<td>Hospitals, Nursing, and Residential Care Facilities</td>
<td>Other Hospitals, Residential Care</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

4.1 Summary of All Entity Impacts

Table 41 presents impacts for all for-profit, non-profit, and local government entities. These costs include all aspects of the rule. Total cost for these entities is estimated to be $1.13 billion per year, at a 3 percent discount rate, for the 197,939 affected entities. None of the affected industries show incremental impacts exceeding one percent of revenues or ten percent of profits.
Table 33. Summary of All Entity Cost and Impacts, by NAICS ($2019)

<table>
<thead>
<tr>
<th>Setting, Size, and NAICS</th>
<th>NAICS Description</th>
<th>Entities</th>
<th>Revenue per Entity</th>
<th>Profit per Entity</th>
<th>Cost per Entity</th>
<th>Cost / Rev.</th>
<th>Cost / Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>10,565</td>
<td>$564,176</td>
<td>$37,209</td>
<td>$1,014</td>
<td>0.18%</td>
<td>2.72%</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td>24,251</td>
<td>$388,409</td>
<td>$25,617</td>
<td>$983</td>
<td>0.25%</td>
<td>3.84%</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td>6,623</td>
<td>$3,507,978</td>
<td>$231,363</td>
<td>$4,399</td>
<td>0.13%</td>
<td>1.90%</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>299</td>
<td>$48,168,028</td>
<td>$3,176,843</td>
<td>$57,602</td>
<td>0.12%</td>
<td>1.81%</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual and Developmental Disability Facilities</td>
<td>6,982</td>
<td>$4,167,280</td>
<td>$274,846</td>
<td>$7,047</td>
<td>0.17%</td>
<td>2.56%</td>
</tr>
<tr>
<td>622220</td>
<td>Residential Mental Health and Substance Abuse Facilities</td>
<td>4,213</td>
<td>$4,157,146</td>
<td>$274,178</td>
<td>$4,841</td>
<td>0.12%</td>
<td>1.77%</td>
</tr>
<tr>
<td>Other Hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical and Emergency Centers</td>
<td>4,401</td>
<td>$7,270,767</td>
<td>$315,472</td>
<td>$2,752</td>
<td>0.04%</td>
<td>0.87%</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>2,806</td>
<td>$324,655,891</td>
<td>$14,086,523</td>
<td>$143,726</td>
<td>0.04%</td>
<td>1.02%</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty (except Psychiatric and Substance Abuse) Hospitals</td>
<td>319</td>
<td>$117,766,436</td>
<td>$5,109,778</td>
<td>$48,187</td>
<td>0.04%</td>
<td>0.94%</td>
</tr>
<tr>
<td>Residential Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>9,255</td>
<td>$13,852,322</td>
<td>$601,040</td>
<td>$18,971</td>
<td>0.14%</td>
<td>3.16%</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>3,882</td>
<td>$9,257,663</td>
<td>$401,682</td>
<td>$9,276</td>
<td>0.10%</td>
<td>2.31%</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>14,346</td>
<td>$2,161,951</td>
<td>$93,805</td>
<td>$5,047</td>
<td>0.12%</td>
<td>2.76%</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>3,226</td>
<td>$2,664,974</td>
<td>$115,631</td>
<td>$3,026</td>
<td>0.11%</td>
<td>2.62%</td>
</tr>
<tr>
<td>Social Assistance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>8,962</td>
<td>$2,006,137</td>
<td>$127,783</td>
<td>$1,622</td>
<td>0.08%</td>
<td>1.27%</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>22,003</td>
<td>$1,789,328</td>
<td>$113,973</td>
<td>$1,343</td>
<td>0.08%</td>
<td>1.18%</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>3,505</td>
<td>$3,248,551</td>
<td>$206,920</td>
<td>$635</td>
<td>0.02%</td>
<td>0.31%</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>3,336</td>
<td>$1,887,067</td>
<td>$120,199</td>
<td>$1,108</td>
<td>0.06%</td>
<td>0.92%</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>3,633</td>
<td>$2,095,263</td>
<td>$133,460</td>
<td>$765</td>
<td>0.04%</td>
<td>0.57%</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>627</td>
<td>$18,505,848</td>
<td>$1,178,750</td>
<td>$2,040</td>
<td>0.01%</td>
<td>0.17%</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>4,180</td>
<td>$3,245,308</td>
<td>$206,713</td>
<td>$3,114</td>
<td>0.10%</td>
<td>1.51%</td>
</tr>
<tr>
<td>Home Healthcare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>23,851</td>
<td>$3,671,192</td>
<td>$233,840</td>
<td>$5,094</td>
<td>0.14%</td>
<td>2.18%</td>
</tr>
<tr>
<td>624120</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>27,640</td>
<td>$1,950,408</td>
<td>$124,233</td>
<td>$2,908</td>
<td>0.15%</td>
<td>2.34%</td>
</tr>
<tr>
<td>Emergency Response</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>3,230</td>
<td>$5,269,214</td>
<td>$335,628</td>
<td>$3,181</td>
<td>0.06%</td>
<td>0.95%</td>
</tr>
<tr>
<td>Firefighter-EMTs</td>
<td></td>
<td>5,801</td>
<td>$4,231,545</td>
<td>$269,533</td>
<td>$2,204</td>
<td>0.05%</td>
<td>0.82%</td>
</tr>
<tr>
<td>All Entities</td>
<td></td>
<td>197,939</td>
<td>$7,956,552</td>
<td>$386,427</td>
<td>$5,718</td>
<td>0.07%</td>
<td>1.48%</td>
</tr>
</tbody>
</table>

4.2 Summary of SBA-Defined Small Entity and Very Small Entity Impacts

Table 42 presents impacts for all SBA-defined small entities. These costs include all aspects of the rule. Total cost for all SBA-small entities is estimated to be $820.0 million per year, at a 3 percent discount rate, for the 192,016 affected small entities. The incremental annualized cost of compliance with the potential proposed rule for the average affected small entity is estimated to be $4,271 in 2019 dollars. Table 43 presents a summary of results for very small entities. The incremental annualized cost of compliance with the final rule for the average affected very small entity is estimated to be $479 in 2019 dollars (Table 43). None of the affected industries for either SBA-small or very small entities show incremental impacts exceeding one percent of revenues or ten percent of profits.
## Table 34. Summary of Small Entity Cost and Impacts, All SBA-Defined Small Entities, by NAICS ($2019)

<table>
<thead>
<tr>
<th>Setting, Size, and NAICS</th>
<th>NAICS Description</th>
<th>Small Entities</th>
<th>Revenue per Entity</th>
<th>Profit per Entity</th>
<th>Cost per Entity</th>
<th>Cost/Rev.</th>
<th>Cost/Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>10,562</td>
<td>$563,190</td>
<td>$37,144</td>
<td>$1,013</td>
<td>0.18%</td>
<td>2.73%</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td>24,240</td>
<td>$386,518</td>
<td>$25,492</td>
<td>$980</td>
<td>0.25%</td>
<td>3.85%</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td>6,383</td>
<td>$3,164,819</td>
<td>$208,730</td>
<td>$3,951</td>
<td>0.12%</td>
<td>1.89%</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>193</td>
<td>$32,876,587</td>
<td>$2,168,321</td>
<td>$39,019</td>
<td>0.12%</td>
<td>1.80%</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual and Developmental Disability Facilities</td>
<td>6,731</td>
<td>$3,540,301</td>
<td>$233,495</td>
<td>$5,912</td>
<td>0.17%</td>
<td>2.53%</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse Facilities</td>
<td>4,065</td>
<td>$3,588,254</td>
<td>$236,657</td>
<td>$4,115</td>
<td>0.11%</td>
<td>1.74%</td>
</tr>
<tr>
<td>Other Hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical and Emergency Centers</td>
<td>3,934</td>
<td>$3,873,352</td>
<td>$168,061</td>
<td>$1,475</td>
<td>0.04%</td>
<td>0.88%</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>2,161</td>
<td>$334,031,072</td>
<td>$14,493,304</td>
<td>$147,615</td>
<td>0.04%</td>
<td>1.02%</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty (except Psychiatric and Substance Abuse) Hospitals</td>
<td>182</td>
<td>$112,646,609</td>
<td>$4,887,634</td>
<td>$46,185</td>
<td>0.04%</td>
<td>0.94%</td>
</tr>
<tr>
<td>Residential Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>623310</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>8,623</td>
<td>$8,163,473</td>
<td>$354,206</td>
<td>$11,271</td>
<td>0.14%</td>
<td>3.18%</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>3,661</td>
<td>$7,850,202</td>
<td>$340,613</td>
<td>$7,892</td>
<td>0.10%</td>
<td>2.32%</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>14,001</td>
<td>$1,186,166</td>
<td>$51,467</td>
<td>$1,497</td>
<td>0.13%</td>
<td>2.91%</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>3,149</td>
<td>$2,533,806</td>
<td>$109,940</td>
<td>$2,890</td>
<td>0.11%</td>
<td>2.63%</td>
</tr>
<tr>
<td>Social Assistance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>8,842</td>
<td>$1,904,250</td>
<td>$121,293</td>
<td>$1,540</td>
<td>0.08%</td>
<td>1.27%</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>21,651</td>
<td>$1,655,678</td>
<td>$105,460</td>
<td>$1,252</td>
<td>0.08%</td>
<td>1.19%</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>3,493</td>
<td>$3,224,984</td>
<td>$205,419</td>
<td>$631</td>
<td>0.02%</td>
<td>0.31%</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>3,336</td>
<td>$1,887,067</td>
<td>$120,199</td>
<td>$1,108</td>
<td>0.06%</td>
<td>0.92%</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>3,619</td>
<td>$2,096,715</td>
<td>$133,552</td>
<td>$766</td>
<td>0.04%</td>
<td>0.57%</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>618</td>
<td>$18,517,695</td>
<td>$1,179,504</td>
<td>$2,040</td>
<td>0.01%</td>
<td>0.17%</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>4,055</td>
<td>$3,182,149</td>
<td>$202,690</td>
<td>$3,033</td>
<td>0.10%</td>
<td>1.50%</td>
</tr>
<tr>
<td>Home Healthcare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>23,122</td>
<td>$1,983,280</td>
<td>$126,327</td>
<td>$2,986</td>
<td>0.15%</td>
<td>2.36%</td>
</tr>
<tr>
<td>624120</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>26,898</td>
<td>$1,583,154</td>
<td>$100,841</td>
<td>$2,263</td>
<td>0.14%</td>
<td>2.24%</td>
</tr>
<tr>
<td>Emergency Response</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>3,113</td>
<td>$3,171,965</td>
<td>$202,042</td>
<td>$2,055</td>
<td>0.06%</td>
<td>1.02%</td>
</tr>
<tr>
<td>Firefighter-EMTs</td>
<td></td>
<td>5,384</td>
<td>$2,223,294</td>
<td>$141,615</td>
<td>$1,415</td>
<td>0.06%</td>
<td>1.00%</td>
</tr>
<tr>
<td>All SBA-Small Entities</td>
<td></td>
<td>192,016</td>
<td>$6,114,919</td>
<td>$297,225</td>
<td>$4,271</td>
<td>0.07%</td>
<td>1.44%</td>
</tr>
</tbody>
</table>

Table 35. Summary of Very Small Entity Cost and Impacts, by NAICS ($2019)

<table>
<thead>
<tr>
<th>Setting, Size, and NAICS</th>
<th>NAICS Description</th>
<th>Very Small Entities</th>
<th>Revenue per Entity</th>
<th>Profit per Entity</th>
<th>Cost per Entity</th>
<th>Cost / Rev.</th>
<th>Cost / Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>621112 Offices of Physicians, Mental Health Specialists</td>
<td>42,934</td>
<td>$333,138</td>
<td>$21,972</td>
<td>$559</td>
<td>0.17%</td>
<td>2.54%</td>
</tr>
<tr>
<td></td>
<td>621330 Offices of Mental Health Practitioners (except Physicians)</td>
<td>10,164</td>
<td>$415,575</td>
<td>$27,409</td>
<td>$666</td>
<td>0.16%</td>
<td>2.43%</td>
</tr>
<tr>
<td></td>
<td>621420 Outpatient Mental Health and Substance Abuse Centers</td>
<td>4,120</td>
<td>$503,658</td>
<td>$33,218</td>
<td>$628</td>
<td>0.12%</td>
<td>1.89%</td>
</tr>
<tr>
<td></td>
<td>622210 Psychiatric and Substance Abuse Hospitals</td>
<td>16</td>
<td>$2,452,646</td>
<td>$161,760</td>
<td>$689</td>
<td>0.03%</td>
<td>0.43%</td>
</tr>
<tr>
<td></td>
<td>623210 Residential Intellectual and Developmental Disability Facilities</td>
<td>3,599</td>
<td>$350,847</td>
<td>$23,140</td>
<td>$533</td>
<td>0.15%</td>
<td>2.30%</td>
</tr>
<tr>
<td></td>
<td>623220 Residential Mental Health and Substance Abuse Facilities</td>
<td>2,016</td>
<td>$573,600</td>
<td>$37,831</td>
<td>$606</td>
<td>0.11%</td>
<td>1.60%</td>
</tr>
<tr>
<td>Other Hospitals</td>
<td>621493 Freestanding Ambulatory Surgical and Emergency Centers</td>
<td>2,746</td>
<td>$1,679,628</td>
<td>$72,878</td>
<td>$581</td>
<td>0.03%</td>
<td>0.80%</td>
</tr>
<tr>
<td></td>
<td>622110 General Medical and Surgical Hospitals</td>
<td>2,651</td>
<td>$1,444,387</td>
<td>$62,671</td>
<td>$588</td>
<td>0.04%</td>
<td>0.94%</td>
</tr>
<tr>
<td></td>
<td>623310 Specialty (except Psychiatric and Substance Abuse) Hospitals</td>
<td>1,916</td>
<td>$1,164,409</td>
<td>$50,523</td>
<td>$325</td>
<td>0.03%</td>
<td>0.64%</td>
</tr>
<tr>
<td>Residential Care</td>
<td>623110 Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>15,897</td>
<td>$461,694</td>
<td>$20,032</td>
<td>$519</td>
<td>0.11%</td>
<td>2.59%</td>
</tr>
<tr>
<td></td>
<td>623311 Continuing Care Retirement Communities</td>
<td>2,193</td>
<td>$979,550</td>
<td>$42,502</td>
<td>$606</td>
<td>0.06%</td>
<td>1.43%</td>
</tr>
<tr>
<td></td>
<td>623312 Assisted Living Facilities for the Elderly</td>
<td>10,464</td>
<td>$503,620</td>
<td>$21,852</td>
<td>$564</td>
<td>0.11%</td>
<td>2.58%</td>
</tr>
<tr>
<td></td>
<td>623990 Other Residential Care Facilities</td>
<td>2,016</td>
<td>$359,287</td>
<td>$15,589</td>
<td>$480</td>
<td>0.13%</td>
<td>3.08%</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>624110 Child and Youth Services</td>
<td>6,706</td>
<td>$468,471</td>
<td>$29,840</td>
<td>$430</td>
<td>0.09%</td>
<td>1.44%</td>
</tr>
<tr>
<td></td>
<td>624190 Other Individual and Family Services</td>
<td>17,263</td>
<td>$388,481</td>
<td>$24,745</td>
<td>$353</td>
<td>0.09%</td>
<td>1.43%</td>
</tr>
<tr>
<td></td>
<td>624210 Community Food Services</td>
<td>2,739</td>
<td>$766,536</td>
<td>$48,825</td>
<td>$404</td>
<td>0.05%</td>
<td>0.83%</td>
</tr>
<tr>
<td></td>
<td>624221 Temporary Shelters</td>
<td>1,874</td>
<td>$517,334</td>
<td>$32,952</td>
<td>$370</td>
<td>0.08%</td>
<td>1.18%</td>
</tr>
<tr>
<td></td>
<td>624229 Other Community Housing Services</td>
<td>2,521</td>
<td>$888,798</td>
<td>$56,613</td>
<td>$330</td>
<td>0.04%</td>
<td>0.58%</td>
</tr>
<tr>
<td></td>
<td>624230 Emergency and Other Relief Services</td>
<td>488</td>
<td>$896,635</td>
<td>$57,112</td>
<td>$371</td>
<td>0.04%</td>
<td>0.65%</td>
</tr>
<tr>
<td></td>
<td>624310 Vocational Rehabilitation Services</td>
<td>1,868</td>
<td>$482,308</td>
<td>$30,721</td>
<td>$294</td>
<td>0.06%</td>
<td>0.96%</td>
</tr>
<tr>
<td>Home Healthcare</td>
<td>621610 Home Health Care Services</td>
<td>32,108</td>
<td>$356,028</td>
<td>$22,678</td>
<td>$465</td>
<td>0.13%</td>
<td>2.05%</td>
</tr>
<tr>
<td></td>
<td>624120 Services for the Elderly and Persons with Disabilities</td>
<td>14,862</td>
<td>$442,262</td>
<td>$28,170</td>
<td>$576</td>
<td>0.13%</td>
<td>2.05%</td>
</tr>
<tr>
<td>Emergency Response</td>
<td>624230 Emergency and Other Relief Services</td>
<td>17,246</td>
<td>$281,716</td>
<td>$17,944</td>
<td>$369</td>
<td>0.13%</td>
<td>2.05%</td>
</tr>
<tr>
<td></td>
<td>624310 Vocational Rehabilitation Services</td>
<td>982</td>
<td>$848,967</td>
<td>$54,076</td>
<td>$618</td>
<td>0.07%</td>
<td>1.14%</td>
</tr>
<tr>
<td>All Very-Small Entities</td>
<td>129,788</td>
<td>$430,914</td>
<td>$25,826</td>
<td>$482</td>
<td>0.11%</td>
<td>1.87%</td>
<td></td>
</tr>
</tbody>
</table>

5. Regulatory Alternatives

This Section describes regulatory alternatives OSHA is considering. The total costs of the potential provisions are summarized in Table 44. OSHA requests comments on the need for each provision, which OSHA may or may not include a potential proposed rule.

Table 36. Total Annualized Costs by Provision ($2019)

<table>
<thead>
<tr>
<th>Draft Rule Provision</th>
<th>Total Annualized Cost, millions, $2019, 3% discount rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paragraph C – Workplace Violence Prevention Plan</td>
<td>$65.1</td>
</tr>
<tr>
<td>Paragraph D – Workplace Hazard Assessment</td>
<td>$63.6</td>
</tr>
<tr>
<td>Paragraph E – Controls</td>
<td>$104.8</td>
</tr>
<tr>
<td>Paragraph F – Training</td>
<td>$908.8</td>
</tr>
<tr>
<td>Paragraph G – Violent Incident Reporting</td>
<td>$73.5</td>
</tr>
<tr>
<td>Total</td>
<td>$1,215.9</td>
</tr>
</tbody>
</table>


5.1 Summary of Regulatory Alternatives

OSHA is considering several regulatory alternatives for the potential proposed rule that modify the scope and applicability of the various provisions:

5.1.1 Overall Scope Alternatives

1. **Standard applies to “patient care” only – not “patient contact”; Exempt patient contact employees from the scope of the rule.** (Scope Alternative #1). This alternative would only cover staff responsible for direct patient care, i.e., that involve hands-on or face-to face contact with patients or clients. Employees that provide support work (i.e., housekeeping, maintenance, meal delivery) would not be covered.

2. **Only include NAICS 6241, Individual and Family Services, in the Social Assistance Setting** (Scope Alternative #2). This alternative removes NAICS 6242, Community Food and Housing, and Emergency and Other Relief Services, and NAICS 6243, Vocational Rehabilitation Services, from the standard’s scope.

3. **Eliminate non-fixed location sectors from the standard** (Emergency Response, Home-based Healthcare & Social Assistance Services) (Scope Alternative #3). This alternative would eliminate coverage among employees in field-based sectors (i.e. emergency medical services, home-based healthcare, home-based social assistance). Only those employed in a fixed facility (i.e. service center, hospital) would be covered.

4. **Expand scope to include locations where healthcare services are provided in correctional facilities and educational settings.** (Scope Option #4). Under this
alternative, locations with embedded healthcare services in correctional facilities and educational settings would be included in the scope of the standard.

5.1.2 Provision-Specific Alternatives

WVPP

5. Staggered periodicity of annual review (biannually or triennially (cost change shown for latter) vs. annually) (WVPP Alternative #1). Under this alternative, employers would review the efficacy of their program on a biennial or triennial (every two or three years, respectively) basis, rather than annually. More frequent review would only be necessary if there are changes in the workplace, such as a change in clientele, or following the investigation of a violent incident. Costs for this alternative presented here assume a triennial basis.

Hazard Assessment

6. Reduce magnitude / size of records review for annual hazard assessments to 1 year of records (Hazard Assessment Alternative #1). This alternative would require employers to assess 1 or 2 years-worth of workplace violence incident records in their annual hazard assessments, instead of 3 years-worth. Employers would review all workplace violence incidents, including threats of physical harm, which occurred in their facility within the previous one 1 or 2 years. Costs for this alternative presented here assume 1 years’ worth of records is reviewed annually.

7. Employers would only focus on OSHA-defined high-risk service areas and not be expected to identify additional high-risk services areas based on their experiences and recordkeeping (no separate high-risk area assessment; no incident-related assessments; keep recordkeeping, incident review) (Hazard Assessment Alternative #2). Under this alternative, employers would not be expected to identify additional high-risk services or high-risk service areas based on their experiences and recordkeeping. The standard would exclude high-risk area hazard assessments and incident-related hazard assessments. Employers would still perform a facility-wide assessment.

8. Change the definition of high-risk service area -- No requirement for employers to conduct establishment-wide hazard assessments based on OSHA’s definitions of high-risk service areas; hazard assessments would be directed to employer-defined high-risk service areas assessments only (Hazard Assessment Alternative #3). Under this alternative, employers would be required to define high-risk service areas rather than OSHA. This alternative would require employers to conduct subsequent hazard assessments in response to a newly-designated high-risk service area; changes in the layout, design, or amenities of the physical workplace; or changes in clientele or adding new high-risk services. The standard would exclude facility-wide hazard assessments and
incident-related hazard assessments. Employers would still perform a high-risk area hazard assessment.

**Engineering Controls**

9. **No Controls - Require only hazard assessment, development of a plan, and provision of training (Hazard Controls Alternative #1).** Under this alternative, the employer would not be responsible for making modifications to mitigate identified hazards and risks (i.e., implement environmental, engineering, and work-practice controls). This alternative would encourage a focus on employer-development of plan, employee participation, training, recording, and evaluation.

10. **Require only that employers implement administrative/work-practice controls -- No requirement for employers to implement environmental or engineering controls (Hazard Controls Alternative #1a).** Under this alternative, the employer would not be responsible for implementing environmental or engineering controls. This alternative would encourage a focus on administrative/work-practice controls (adjusting staffing patterns, communication practices, incident response procedures, etc.), employer-development of plan, employee participation, training, recording, and evaluation.

11. **Remove requirement for all employers to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #2).** Under this alternative, the employer would not be responsible for developing a standard operating procedure for active shooters or mass casualty situations.

12. **Remove requirement for small entities to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #3).** Under this alternative, small entities would not be responsible for developing a standard operating procedure for active shooters or mass casualty situations.

**Training**

13. **Remove annual training; retain initial training (Training Alternative #1).** Under this alternative, employees with patient or client contact or care would only complete an initial training, and supplemental training as necessary. Following the initial training, these employees would receive supplemental training whenever there are significant changes to any workplace violence-related procedures or controls or if employees demonstrate a need for refresher training.

14. **Require training for a more limited subset of employees (Training Alternative #2).** Under this alternative, only employees with direct patient care and violence incident response duties would be required to complete training. Employees with patient contact (i.e. physically close to patients when performing duties), not responsible for patient care, would not have to complete any training.
15. Reduce the expected number of training hours (Training Alternative #3). This alternative would be less strict than the proposed three-tier training program. This alternative would include different training requirements based on patient care or contact, and the hours of initial and supplemental instruction would be reduced by half.

16. Require refresher training every 3 years or 2 years instead of annually (Training Alternatives #4 and #4a). This alternative would require employers only perform refresher training for employees every 3 years or every 2 years.

17. Employees specifically-designated to respond to workplace violence incidents (e.g. incident response team members) receive incident response training; all others receive the WPV training specified under the primary/default framework (Training Option #1). Under this option, only employees with members of a workplace violence response team, or individual responders, would receive incident response training; all others receive the WPV training specified under the primary/default framework.

18. Require 24 hours of training for small facilities (≤2 employees on site) (Training Option #2). This option would require an advanced level of instruction for employees working in an establishment with only one or two employees on site (e.g., small behavioral health group home).

19. Reduction of expectation of training length for the most advanced level of employee workplace violence prevention training (Training Sensitivity Test #1). The draft regulatory text that OSHA has provided has not prescribed any specific length of time that would be associated with the various tiers of employee training curricula. However, OSHA has provided some estimates in these supplementary materials. The highest tier of training, that for those employees expected to respond to workplace violence incidents (and their supervisors), would remain the most extensive. However, a requirement to provide 24 hours of instruction would no longer be expected of any employer -- the expectation would be that employees could receive adequate instruction within a curriculum of consisting of at least 8 hours of training.

Incident Investigation & Recordkeeping

20. Require post-incident investigations only for workplace violence incidents involving physical assault. This alternative would only require post-incident investigations if the workplace violence incident involved physical assaults, regardless if an injury was sustained. If the violence incident does not include assault (i.e. threats), no investigation needs to be conducted.

21. Require post-incident medical and psychological evaluations and treatment. Under this alternative, employers incur costs to provide any required or recommended post-incident medical and psychological evaluations and treatment for the affected employee for a period of one year. The implementation of all requirements of this standard shall be
at no cost to the employee. All time required by an employee to comply with the standard, including time for training, post-incident medical and psychological evaluations/treatment, and reasonable travel time (as appropriate) shall be considered compensable time. Costs presented here assume 1 hour of evaluation per week for one year, with $5 of travel time per session; and, total alternative cost is based on average annual per employee cost applied to the estimated number of OSHA recordable incidents.
## 5.2 Summary of Costs for Regulatory Alternatives

Table 37. Annualized Costs for Regulatory Alternatives ($2019)  

<table>
<thead>
<tr>
<th>Regulatory Alternative, Option, or Sensitivity Test</th>
<th>Change in Annualized Cost ($)</th>
<th>Percent Change in Annualized Cost</th>
<th>Annualized Cost, Alternative (3%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scope</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Standard applies to “patient care” only – not “patient contact”; Exempt patient contact employees from the scope of the rule. (Scope Alternative #1)</td>
<td>($23,516,110)</td>
<td>-1.9%</td>
<td>$1,192,336,875</td>
</tr>
<tr>
<td>2. Only include NAICS 6241, Individual and Family Services, in the Social Assistance Setting (Scope Alternative #2)</td>
<td>($23,997,530)</td>
<td>-2.0%</td>
<td>$1,191,855,456</td>
</tr>
<tr>
<td>3. Eliminate non-fixed location sectors from the standard (Emergency Response, Home-based Healthcare &amp; Social Assistance Services) (Scope Alternative #3)</td>
<td>($285,391,219)</td>
<td>-23.5%</td>
<td>$930,461,766</td>
</tr>
<tr>
<td>4. Expand scope to include locations where healthcare services are provided in correctional facilities and educational settings. (Scope Option #4)</td>
<td>$30,155,251</td>
<td>2.5%</td>
<td>$1,246,008,236</td>
</tr>
<tr>
<td><strong>C. WVPP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Staggered periodicity of annual review (biannually or triennially (cost change shown for latter) vs. annually) (WVPP Alternative #1)</td>
<td>($26,818,331)</td>
<td>-2.2%</td>
<td>$1,189,034,654</td>
</tr>
<tr>
<td><strong>D. Hazard Assessment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Reduce magnitude / size of records review for annual hazard assessments to 1 year of records (Hazard Assessment Alternative #1)</td>
<td>($5,663,316)</td>
<td>-0.5%</td>
<td>$1,210,189,669</td>
</tr>
<tr>
<td>7. Employers would only focus on OSHA-defined high-risk service areas and not be expected to identify additional high-risk services areas based on their experiences and recordkeeping (no separate high-risk area assessment; no incident-related assessments; keep recordkeeping, incident review) (Hazard Assessment Alternative #2)</td>
<td>($49,264,063)</td>
<td>-4.1%</td>
<td>$1,166,588,922</td>
</tr>
<tr>
<td>8. Change the definition of high-risk service area -- No requirement for employers to conduct establishment-wide hazard assessments based on OSHA’s definitions of high-risk service areas; hazard assessments would be directed to employer-defined high-risk service areas assessments only (Hazard Assessment Alternative #3)</td>
<td>($157,322,225)</td>
<td>-12.9%</td>
<td>$1,058,530,760</td>
</tr>
<tr>
<td><strong>E. Hazard Controls</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Require only hazard assessment, development of a plan, and provision of training (Hazard Controls Alternative #1)</td>
<td>($101,667,773)</td>
<td>-8.4%</td>
<td>$1,114,185,212</td>
</tr>
<tr>
<td>10. Require only that employers implement administrative/work-practice controls -- No requirement for employers to implement environmental or engineering controls (Hazard Controls Alternative #1a)</td>
<td>($93,996,083)</td>
<td>-7.7%</td>
<td>$1,121,856,902</td>
</tr>
<tr>
<td>11. Remove requirement for all employers to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #2)</td>
<td>($9,965,590)</td>
<td>-0.8%</td>
<td>$1,205,887,395</td>
</tr>
</tbody>
</table>
### Table 37. Annualized Costs for Regulatory Alternatives ($2019)

<table>
<thead>
<tr>
<th>Regulatory Alternative, Option, or Sensitivity Test</th>
<th>Change in Annualized Cost ($) (3%)</th>
<th>Percent Change in Annualized Cost</th>
<th>Annualized Cost, Alternative (3%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Remove requirement for small entities to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #3)</td>
<td>($1,047,187)</td>
<td>-0.1%</td>
<td>$1,214,805,798</td>
</tr>
<tr>
<td><strong>F. Training</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Remove annual training; retain initial training (Training Alternative #1)</td>
<td>($755,090,859)</td>
<td>-62.1%</td>
<td>$460,762,126</td>
</tr>
<tr>
<td>14. Require training for a more limited subset of employees (Training Alternative #2)</td>
<td>($19,650,597)</td>
<td>-1.6%</td>
<td>$1,196,202,388</td>
</tr>
<tr>
<td>15. Reduce the expected number of training hours (Training Alternative #3)</td>
<td>($454,405,330)</td>
<td>-37.4%</td>
<td>$761,447,655</td>
</tr>
<tr>
<td>16. Require refresher training every 3 years instead of annually (Training Alternative #4)</td>
<td>($510,796,039)</td>
<td>-42.0%</td>
<td>$705,056,946</td>
</tr>
<tr>
<td>16a. Require refresher training every 2 years instead of annually (Training Alternative #4a)</td>
<td>($419,738,961)</td>
<td>-34.5%</td>
<td>$796,114,024</td>
</tr>
<tr>
<td>17. Employees specifically-designated to respond to workplace violence incidents (e.g. incident response team members) receive incident response training; all others receive the WPV training specified under the primary/default framework (Training Option #1)</td>
<td>$299,590,333</td>
<td>24.6%</td>
<td>$1,515,443,318</td>
</tr>
<tr>
<td>18. Require 24 hours of training for small facilities (≤2 employees on site) (Training Option #2)</td>
<td>$14,139,424</td>
<td>1.2%</td>
<td>$1,229,992,409</td>
</tr>
<tr>
<td>19. Reduction of expectation of training length for the most advanced level of employee workplace violence prevention training (Training Sensitivity Test #1)</td>
<td>($19,848,474)</td>
<td>-1.6%</td>
<td>$1,196,004,511</td>
</tr>
<tr>
<td><strong>G. Violent Incident Investigation &amp; Recordkeeping</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Require post-incident investigations only for workplace violence incidents involving physical assault (Incident Investigation Alternative #1)</td>
<td>($13,729,830)</td>
<td>-1.1%</td>
<td>$1,202,123,156</td>
</tr>
<tr>
<td>21. Require post-incident medical and psychological evaluations and treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For WPV Recordable, Lost-Work Incidents (Post-incident Evaluations Options #1)</td>
<td>$108,746,045</td>
<td>8.9%</td>
<td>$1,324,599,030</td>
</tr>
<tr>
<td>For WPV Recordable, Non-Lost-Work Incidents (Post-incident Evaluations Options #2)</td>
<td>$231,641,450</td>
<td>19.1%</td>
<td>$1,447,494,435</td>
</tr>
<tr>
<td>For Total Recordable WPV Incidents (Post-incident Evaluations Options #3)</td>
<td>$340,387,495</td>
<td>28.0%</td>
<td>$1,556,240,480</td>
</tr>
</tbody>
</table>

**Effective Date of the Standard Alternative #1:** Extension of compliance date for requirements in paragraphs (e) Control Measures and (f) Training or any other provisions in this draft standard might require more than six month to come into compliance.

**General Alternative:** OSHA opts to take no action on this draft standard on Prevention of Workplace Violence in Healthcare and Social Assistance, and continues to address workplace violence hazards in healthcare and social assistance solely through use of the General Duty Clause.

OSHA, 2022.
6. References


https://apps.bea.gov/iTable/iTable.cfm?reqid=19&step=2#reqid=19&step=2&isuri=1&1921=survey


Appendix A: Methodology for Estimating Potentially Regulated Entities

This Appendix describes additional details and data underlying OSHA’s industry profile of entities potentially regulated by the draft regulatory framework, including the number of entities and employees in each setting for private and public entities. Sections A.1 – A.4 present, respectively, private for-profit entities, private non-profit entities, state and local government entities, and a summary of all affected entities. Then, in Section A.5, SBA/RFA-defined small entities and very small entities are profiled for all affected industries. Finally, in Section A.6, OSHA presents a profile of direct patient/client/resident care and patient/client/resident contact employees affected by the draft regulatory framework.

A.1 For-Profit Entities

OSHA used data from the U.S. Census’ 2017 County Business Patterns (CBP) to estimate the number of entities, establishments, employees, and annual revenues of for-profit entities in the potentially regulated industries. Firms, establishments, employees, and revenue were obtained by NAICS code directly from the 2017 CBP data, by employment size (CBP, 2019a; CBP, 2019b). All revenue data were then adjusted to 2019 dollars based on the Bureau of Economic Analysis implicit price deflator for GDP (BEA, 2019).

OSHA also made two adjustments to the data to separate for-profit entities from the original CBP dataset.

- **Account for government hospitals in County Business Patterns**

  The Census’ CBP data include some government hospitals (NAICS 622). These entities are also reported separately in the CBP by-ownership data series (CBP, 2019b). OSHA removed these from the primary CBP data by subtracting from the overall totals, the reported figures for government entities, establishments, employees, and revenue, by NAICS code.

- **Account for non-profit entities in County Business Patterns**

  The Census’ CBP data also includes non-profit entities. OSHA deducted from the total, the estimates for non-profit entities, by NAICS code, obtained from CBP’s by-ownership data series. OSHA used a specialized data source in the case of private fire departments since this specific subcategory is not present in the CBP data. OSHA relied on data from the U.S. Fire Administration’s (USFA) National Fire Department Registry (USFA, 2018), which includes a profile of fire departments and related services. This sub-population of potential regulated entities is part of the health care setting identified within the scope of OSHA’s Emergency Response prospective rulemaking (see SBREFA SBAR Panel Report; https://www.osha.gov/emergency-response/rulemaking).

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32 https://www.census.gov/programs-surveys/susb/technical-documentation/methodology.html
33 The CBP data includes some government establishments in four NAICS industries: General Medical and Surgical Hospitals (622110), Psychiatric and Substance Abuse Hospitals (622210), Specialty (except Psychiatric and Substance Abuse) Hospitals (622310), Nursing Care Facilities (Skilled Nursing Facilities) (623110). For this PIRFA, OSHA assumed that the number of government entities is identical to the number of government establishments.
The USFA registry indicates that there are 15,040 private responders nationwide. Due to chronic under-reporting of these emergency specialists and the uncertainty surrounding budgetary constraints at the local governmental level, OSHA doubled its estimate for private firefighters, and for the revised total of 30,080 responders, the agency estimated that there are approximately 872 private fire response establishments. Next, OSHA estimated that 53 percent of private fire departments have staff cross-trained as EMTs, based on the percentage of all fire departments with cross-trained personnel, including both public and private. Applying this percentage to the estimate for private responders and their employers (30,080 responders, 872 employers) resulted in an estimated 461 private establishments and 16,338 private responders. The number of private firefighting entities and associated revenue were estimated based on the ratio of establishments to entities, and revenue per establishment, for the Ambulance Services NAICS code (i.e., the other component of the Emergency Responder health care setting).

Table A-1 presents summary statistics for the for-profit sector, by health care setting. It shows there are about 122,000 entities, 175,000 establishments, and 5.8 million employees in private, for-profit industries potentially affected by a proposed workplace violence standard.

### Table A-1. Summary of In-Scope Industries, For-Profit

<table>
<thead>
<tr>
<th>Healthcare or Social Assistance Setting</th>
<th>Entities</th>
<th>Establishments</th>
<th>Employees</th>
<th>Revenue ($2019, billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Facilities</td>
<td>41,202</td>
<td>58,344</td>
<td>597,823</td>
<td>$47.6</td>
</tr>
<tr>
<td>Hospitals, other than mental health</td>
<td>4,777</td>
<td>8,754</td>
<td>948,597</td>
<td>$179.3</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>24,289</td>
<td>37,589</td>
<td>1,957,969</td>
<td>$145.4</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>39,132</td>
<td>52,714</td>
<td>1,980,102</td>
<td>$108.6</td>
</tr>
<tr>
<td>Social Assistance Facilities</td>
<td>9,828</td>
<td>13,744</td>
<td>119,947</td>
<td>$9.6</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>2,332</td>
<td>4,187</td>
<td>157,703</td>
<td>$14.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>121,561</strong></td>
<td><strong>175,332</strong></td>
<td><strong>5,762,141</strong></td>
<td><strong>$504.8</strong></td>
</tr>
</tbody>
</table>

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

### A.2 Non-Profit Entities

OSHA used data from the CBP-by-ownership data series to estimate the number and size of non-profit establishments and employees by six-digit NAICS code, as well as the employment size classification for non-profit establishments. OSHA applied the overall firms per establishment ratio to the number of non-profit firms and the overall per-employee revenue in order to estimate revenue for non-profit establishments.34

34 County Business Patterns (CBP) is an annual series published by the U.S. Census Bureau that provides subnational economic data by industry. The CBP series includes the number of establishments, employment during a given week, first quarter payroll, and annual payroll.

The 2017 CBP data include entity revenue by employment size category. OSHA uses these data to estimate the average revenue per firm, by NAICS code and employment-size category. OSHA first identifies the SBA-designated revenue threshold for each NAICS. Next, OSHA aggregates the number of firms across employment-sizes for all
Table A-2 summarizes OSHA’s estimates for non-profit entities potentially affected by a workplace violence standard, which include about 68,400 entities employing approximately 7.1 million employees.

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>Entities</th>
<th>Establishments</th>
<th>Employees</th>
<th>Revenue ($2019, billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Facilities</td>
<td>11,460</td>
<td>32,549</td>
<td>748,537</td>
<td>$51.0</td>
</tr>
<tr>
<td>Hospitals, other than mental health</td>
<td>1,995</td>
<td>4,187</td>
<td>3,902,235</td>
<td>$731.2</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>6,254</td>
<td>9,845</td>
<td>760,479</td>
<td>$56.7</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>11,931</td>
<td>15,432</td>
<td>652,066</td>
<td>$32.1</td>
</tr>
<tr>
<td>Social Assistance Facilities</td>
<td>35,755</td>
<td>49,568</td>
<td>990,072</td>
<td>$95.0</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>995</td>
<td>1,787</td>
<td>43,441</td>
<td>$3.9</td>
</tr>
<tr>
<td>Total</td>
<td>68,391</td>
<td>113,368</td>
<td>7,096,830</td>
<td>$970.0</td>
</tr>
</tbody>
</table>

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

A.3 State and Local Government Entities

OSHA obtains estimates of the overall population of State and Local government entities from the Bureau of Labor Statistics’ Quarterly Census of Employment and Wages (QCEW), 2017 annual estimates (BLS 2018). The QCEW program reports establishments and employees, including for government, at varying NAICS industry classifications and geographic levels of aggregation. Due to OSHA’s delegation of jurisdictional authority to other federal entities through the OSH Act and memoranda of understanding, federal entities are not included in OSHA’s analysis of the potential rule. Only public entities that are in OSHA state-plan states are under OSHA’s jurisdiction and therefore this analysis also excludes public entities in non-state-plan states.

Table A-3 presents the states that have state plans and their public entities are included in the analysis:

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35 Section 19, Federal Agency Safety Programs and Responsibilities, of the OSH Act states, “It shall be the responsibility of the head of each Federal agency . . . to establish and maintain an effective and comprehensive occupational safety and health program which is consistent with the standards promulgated under section 6 [of the OSH Act].” 29 U.S.C. § 668(a). Although section 19 covers all Federal employees, Executive Order 12196 directs the Secretary of Labor to cooperate and consult with the heads of agencies in the legislative and judicial branches of the government to help them adopt safety and health programs. Exec. Order No. 12196, 45 Fed. Reg. 12769 (Feb. 26, 1980).
Table A-3. State-Plan States under OSHA’s Jurisdiction

<table>
<thead>
<tr>
<th>State-Plan States</th>
<th>Alaska</th>
<th>Illinois</th>
<th>Maryland</th>
<th>New Mexico</th>
<th>Tennessee</th>
<th>Wyoming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>California</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hawaii</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


For potentially regulated public fire departments with firefighters cross-trained as EMTs, OSHA relied on estimates from USFA (USFA, 2018). OSHA excluded federal entities, public entities in non-state plan states, entities that do not report having any firefighters, and non-firefighting personnel included in the USFA registry data. Further, the analysis excluded volunteers and all-volunteer emergency service organizations in state plan states that do not cover volunteers. OSHA estimates that there are 10,679 in-scope public fire departments and 493,594 associated public responders. Similar to the estimation method described above for the private sector, OSHA estimated that 53 percent of these potentially regulated departments and responders include cross-trained EMTs, resulting in a total of 5,649 public fire departments and 261,091 public responders that are in scope. In addition, 98 percent of public entities are operated by local governments versus state governments (USFA, 2018). Based on this estimate, OSHA disaggregated the in-scope public firefighter entity population into state and local government categories.

Table A-4 and Table A-5 summarize the number of estimated state and local government entities and employees, by healthcare setting that are in scope of the draft workplace violence regulatory framework. There are a total of approximately 12,000 entities and 1.1 million employees in the overall government sector estimated to be in scope.

Table A-4. Summary of In-Scope Industries, State-Government

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>Entities</th>
<th>Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Facilities</td>
<td>1,735</td>
<td>123,752</td>
</tr>
<tr>
<td>Hospitals, other than mental health</td>
<td>170</td>
<td>154,459</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>531</td>
<td>23,137</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>82</td>
<td>11,564</td>
</tr>
<tr>
<td>Social Assistance Facilities</td>
<td>1,136</td>
<td>55,196</td>
</tr>
</tbody>
</table>

### Table A-5. Summary of In-Scope Industries, Local-Government

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>Entities</th>
<th>Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Responders</td>
<td>104</td>
<td>4,821</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,759</strong></td>
<td><strong>372,930</strong></td>
</tr>
</tbody>
</table>


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

### Table A-6. Summary of Potentially Regulated Entities

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>For profit</th>
<th>Non-Profit</th>
<th>State and Local Government</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entities</td>
<td>Establishments</td>
<td>Employees</td>
</tr>
<tr>
<td>Behavioral Health Facilities</td>
<td>41,202</td>
<td>4,777</td>
<td>24,289</td>
</tr>
<tr>
<td>Hospitals, other than mental health</td>
<td>58,344</td>
<td>8,754</td>
<td>37,589</td>
</tr>
<tr>
<td>Social Assistance Facilities</td>
<td>597,823</td>
<td>948,597</td>
<td>1,957,969</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>7,988</td>
<td>720,926</td>
<td><strong>5,762,141</strong></td>
</tr>
</tbody>
</table>

In total, OSHA estimates there are approximately 201,700 entities employing 14 million people within the scope of the regulatory framework, as summarized in Table A-6.
A.5 Small and Very Small Potentially-Regulated Entities

Private Entities

The 2017 CBP data includes entity revenue by employment size category. OSHA uses these data to estimate the average revenue per firm, by NAICS code and employment-size category. OSHA aggregates the number of firms across employment-sizes for all firms with average revenue below the applicable SBA revenue threshold. This results in the number of SBA-defined small private firms by NAICS code. OSHA estimates the percentage of firms that are small for each NAICS code, and applies that percentage to the number of for-profit entities to estimate the number of for-profit, small entities. OSHA uses this approach because the CBP data do not provide data on revenue by ownership category. OSHA uses the same approach to estimate the number of establishments and employees for small entities from the 2017 CBP Statistics of U.S. Businesses data. For very small entities, those with fewer than 20 employees, OSHA relies directly on the 2017 CBP data with its employment size categories.

Table A-7 presents the resulting number of entities, establishments, and employees associated with small and very small for-profit entities estimated to be in scope of the draft regulatory framework and therefore included in the analysis.

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>Behavioral Health Facilities</th>
<th>Hospitals, other than mental health</th>
<th>Residential Care Facilities</th>
<th>Home Healthcare Services</th>
<th>Social Assistance</th>
<th>Emergency Responders</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>54,670</td>
<td>7,697</td>
<td>31,240</td>
<td>51,573</td>
<td>47,382</td>
<td>9,136</td>
<td>201,698</td>
</tr>
<tr>
<td>Entities</td>
<td>92,900</td>
<td>13,866</td>
<td>48,131</td>
<td>68,656</td>
<td>65,111</td>
<td>11,782</td>
<td>300,447</td>
</tr>
<tr>
<td>Establishments</td>
<td>1,483,432</td>
<td>5,379,629</td>
<td>2,762,638</td>
<td>2,659,449</td>
<td>1,201,232</td>
<td>466,447</td>
<td>13,952,827</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>SBA-Defined Small Entities</th>
<th>Very Small Entities (Fewer than 20 Employees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Facilities</td>
<td>40,587</td>
<td>36,528</td>
</tr>
<tr>
<td>Hospitals, other than mental health</td>
<td>3,908</td>
<td>2,441</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>23,077</td>
<td>13,196</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>37,913</td>
<td>24,753</td>
</tr>
<tr>
<td>Social Assistance Facilities</td>
<td>9,539</td>
<td>8,291</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>2,392</td>
<td>1,165</td>
</tr>
<tr>
<td>Total</td>
<td>117,416</td>
<td>86,375</td>
</tr>
</tbody>
</table>

37 The employment size categories are: entities with 4 employees or less; 5-9 employees; 10-19 employees; 20-99 employees; 100-499 employees; and 500 or more employees.
OSHA estimates the number of non-profits that are very small by assuming the same proportion are very small as in the combined for-profit and non-profit entity data. Table A-8 presents RFA-defined small and very small non-profit entities. RFA-defined small non-profit statistics are the same as total non-profit statistics.

### Table A-8. Non-Profit, In-Scope, Small and Very Small Entities

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>RFA-Defined Small Entities</th>
<th>Very Small Entities (Less than 20 Employees)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Firms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Facilities</td>
<td>11,460</td>
<td>6,362</td>
</tr>
<tr>
<td>Other Hospitals</td>
<td>1,995</td>
<td>278</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>6,254</td>
<td>2,670</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>11,931</td>
<td>7,254</td>
</tr>
<tr>
<td>Social Assistance Facilities</td>
<td>35,755</td>
<td>24,981</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>995</td>
<td>531</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>68,391</strong></td>
<td><strong>42,075</strong></td>
</tr>
</tbody>
</table>

| **Establishments**                  |                           |                                             |
| Behavioral Health Facilities        | 32,549                    | 6,452                                       |
| Other Hospitals                     | 4,187                     | 282                                         |
| Residential Care Facilities         | 9,845                     | 2,693                                       |
| Home Healthcare Services            | 15,432                    | 7,279                                       |
### Healthcare Setting

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>RFA-Defined Small Entities</th>
<th>Very Small Entities (Less than 20 Employees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Assistance Facilities</td>
<td>49,568</td>
<td>25,200</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>1,787</td>
<td>537</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>113,368</strong></td>
<td><strong>42,441</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employees</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Facilities</td>
<td>748,537</td>
<td>39,097</td>
</tr>
<tr>
<td>Other Hospitals</td>
<td>3,902,235</td>
<td>1,728</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>760,479</td>
<td>18,212</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>652,066</td>
<td>42,144</td>
</tr>
<tr>
<td>Social Assistance Facilities</td>
<td>990,072</td>
<td>128,654</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>43,441</td>
<td>4,959</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,096,830</strong></td>
<td><strong>234,794</strong></td>
</tr>
</tbody>
</table>


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

### Public Entities

Consistent with RFA and SBA guidance, a small governmental jurisdiction is a city, county, town, township, village, school district, or special district with a population of less than 50,000. Small, public entities within the scope of the draft regulatory framework include entities associated with local governments, where the local government serves a population of less than 50,000.

OSHA obtains estimates of state and local government entities from the BLS QCEW (BLS 2018). The QCEW includes detailed 6-digit NAICS industry data at the national level for state and local government. To estimate the subset of local government entities that are small, OSHA used additional QCEW data that were specified geographically by county and are available at the 4-digit NAICS industry level, along with 2017 county-level population data from the Census’ American Community Survey (ACS 2018). Using these data, OSHA estimated the percentage of local government entities—looking at county-level entities—that serve small counties (i.e., with a population of less than 50,000), for each affected healthcare setting. OSHA then applied these proportions to the national estimates of all local government entities, by industry, to estimate the subset that are small. To estimate the number of employees in these small local government entities, OSHA assumed small entity employment is proportional to the percentage of employees in small entities based on the original CBP data which includes a blend of for-profit, non-profit, and public hospitals.

For in-scope fire departments and cross-trained EMT personnel, the available data on small governmental jurisdictions does not allow OSHA to identify the number of fire departments that serve small governments. In order to derive these estimates, OSHA first obtained an estimate of the overall number of people served per employee from Firehouse Magazine (2018) survey data. This survey found that each firefighter serves an average of 647 people. Based on this, OSHA estimated that fire departments with up to 77 employees could serve populations of

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39 Part one of Firehouse Magazine’s (2018) 2017 National Run Survey presents data from a survey of 259 fire departments, which has statistics about population served and staffing.
Taking all departments in the U.S. Fire Administration’s (USFA, 2018) registry data with 77 or fewer employees then gives an estimate of how many departments serve populations of fewer than 50,000.

Table A-9 gives summary statistics by healthcare setting for small and very small government entities.

**Table A-9. Local Government In-Scope, Small and Very Small Entities**

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>RFA-Defined Small Entities</th>
<th>Very Small Entities&lt;br&gt;(Less than 20 Employees)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entities</td>
<td>Employees</td>
</tr>
<tr>
<td>Behavioral Health Facilities</td>
<td>127</td>
<td>2,491</td>
</tr>
<tr>
<td>Other Hospitals</td>
<td>374</td>
<td>70,202</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>103</td>
<td>7,069</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>175</td>
<td>4,582</td>
</tr>
<tr>
<td>Social Assistance Facilities</td>
<td>321</td>
<td>4,191</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>5,109</td>
<td>146,797</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,210</td>
<td>235,333</td>
</tr>
</tbody>
</table>

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

Table A-10 presents a summary profile of SBA/RFA-defined small and very small entities affected by the draft regulatory framework.
Table A-10. Summary of Small Entities within the In-Scope Health Care and Social Assistance Industry

Private, For Profit

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>SBA-Defined Small Entities</th>
<th>Very Small Entities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entities</td>
<td>Establishments</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>40,587</td>
<td>48,900</td>
</tr>
<tr>
<td>Other Hospitals (excluding BH)</td>
<td>3,908</td>
<td>4,182</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>23,077</td>
<td>25,419</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>37,913</td>
<td>42,077</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>9,539</td>
<td>11,952</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>2,392</td>
<td>2,898</td>
</tr>
<tr>
<td>Total</td>
<td>117,416</td>
<td>135,427</td>
</tr>
</tbody>
</table>

Table A-10, continued. Summary of Small Entities In-Scope Health Care and Social Assistance Industry

Private, Non-Profit

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>RFA-Defined Small Entities (All Non-Profits)</th>
<th>Very Small Entities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entities</td>
<td>Establishments</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>11,460</td>
<td>32,549</td>
</tr>
<tr>
<td>Other Hospitals (excluding BH)</td>
<td>1,995</td>
<td>4,187</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>6,254</td>
<td>9,845</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>11,931</td>
<td>15,432</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>35,755</td>
<td>49,568</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>995</td>
<td>1,787</td>
</tr>
<tr>
<td>Total</td>
<td>68,391</td>
<td>113,368</td>
</tr>
</tbody>
</table>
### Table A-10, continued. Summary of Small Entities In-Scope Health Care and Social Assistance Industry

#### Public, State

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>RFA-Defined Small Entities</th>
<th>Very Small Entities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entities</td>
<td>Establishments</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Hospitals (excluding BH)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Public, Local

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>RFA-Defined Small Entities</th>
<th>Very Small Entities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entities</td>
<td>Establishments</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>127</td>
<td>2,491</td>
</tr>
<tr>
<td>Other Hospitals (excluding BH)</td>
<td>374</td>
<td>70,202</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>103</td>
<td>7,069</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>175</td>
<td>4,582</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>321</td>
<td>4,191</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>5,109</td>
<td>146,797</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,210</td>
<td>235,333</td>
</tr>
</tbody>
</table>
Table A-10, continued. Summary of Small Entities In-Scope Health Care and Social Assistance Industry

<table>
<thead>
<tr>
<th>Healthcare Setting</th>
<th>SBA/RFA-Defined Small Entities</th>
<th>Very Small Entities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entities</td>
<td>Establishments</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>52,047</td>
<td>81,576</td>
</tr>
<tr>
<td>Other Hospitals (excluding BH)</td>
<td>5,903</td>
<td>8,743</td>
</tr>
<tr>
<td>Residential Care Facilities</td>
<td>29,331</td>
<td>35,367</td>
</tr>
<tr>
<td>Home Healthcare Services</td>
<td>49,844</td>
<td>57,684</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>45,293</td>
<td>61,841</td>
</tr>
<tr>
<td>Emergency Responders</td>
<td>3,388</td>
<td>9,794</td>
</tr>
<tr>
<td>Total</td>
<td>185,806</td>
<td>255,005</td>
</tr>
</tbody>
</table>

Note: Due to rounding, figures in the columns and rows may not sum to the totals shown.
Appendix B: Direct Patient/Client/Resident Care and Contact Occupations

Table B-1, Table B-2, and Table B-3 below list direct patient/client/resident care and patient contact occupations, and supervisory staff occupations, as identified by OSHA, in the BLS Occupational Employment Statistics data (BLS, 2019).

Table B-1. Direct Patient/Client/Resident Care Occupations

<table>
<thead>
<tr>
<th>BLS Occupation Code, detailed</th>
<th>Occupation^40</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-3031</td>
<td>Clinical, Counseling, and School Psychologists</td>
</tr>
<tr>
<td>19-3039</td>
<td>Psychologists, All Other</td>
</tr>
<tr>
<td>21-1015</td>
<td>Rehabilitation Counselors</td>
</tr>
<tr>
<td>21-1018</td>
<td>Substance Abuse, Behavioral Disorder, and Mental Health Counselors</td>
</tr>
<tr>
<td>21-1019</td>
<td>Counselors, All Other</td>
</tr>
<tr>
<td>21-1021</td>
<td>Child, Family, and School Social Workers</td>
</tr>
<tr>
<td>21-1022</td>
<td>Healthcare Social Workers</td>
</tr>
<tr>
<td>21-1023</td>
<td>Mental Health and Substance Abuse Social Workers</td>
</tr>
<tr>
<td>21-1029</td>
<td>Social Workers, All Other</td>
</tr>
<tr>
<td>21-1093</td>
<td>Social and Human Service Assistants</td>
</tr>
<tr>
<td>21-1094</td>
<td>Community Health Workers</td>
</tr>
<tr>
<td>21-1099</td>
<td>Community and Social Service Specialists, All Other</td>
</tr>
<tr>
<td>29-1011</td>
<td>Chiropractors</td>
</tr>
<tr>
<td>29-1021</td>
<td>Dentists, General</td>
</tr>
<tr>
<td>29-1022</td>
<td>Oral and Maxillofacial Surgeons</td>
</tr>
<tr>
<td>29-1023</td>
<td>Orthodontists</td>
</tr>
<tr>
<td>29-1024</td>
<td>Prosthodontists</td>
</tr>
<tr>
<td>29-1029</td>
<td>Dentists, All Other Specialists</td>
</tr>
<tr>
<td>29-1041</td>
<td>Optometrists</td>
</tr>
<tr>
<td>29-1061</td>
<td>Anesthesiologists</td>
</tr>
<tr>
<td>29-1062</td>
<td>Family and General Practitioners</td>
</tr>
<tr>
<td>29-1063</td>
<td>Internists, General</td>
</tr>
</tbody>
</table>

^40 Some of the occupations on this list may not typically work in a setting covered by this draft rule. For example, massage therapists do not typically work in settings covered by the draft rule and most will not be covered. However, when they work in a workplace that is covered by the draft rule (e.g., a hospital), they will be covered. See OSHA, 2022 [Excel workbook], tab “BLS OES 2018”, for the profile of affected BLS occupation codes.
Table B-2, continued. Direct Patient/Client/Resident Care Occupations

<table>
<thead>
<tr>
<th>BLS Occupation Code, detailed</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>29-1064</td>
<td>Obstetricians and Gynecologists</td>
</tr>
<tr>
<td>29-1065</td>
<td>Pediatricians, General</td>
</tr>
<tr>
<td>29-1066</td>
<td>Psychiatrists</td>
</tr>
<tr>
<td>29-1067</td>
<td>Surgeons</td>
</tr>
<tr>
<td>29-1069</td>
<td>Physicians and Surgeons, All Other</td>
</tr>
<tr>
<td>29-1071</td>
<td>Physician Assistants</td>
</tr>
<tr>
<td>29-1081</td>
<td>Podiatrists</td>
</tr>
<tr>
<td>29-1122</td>
<td>Occupational Therapists</td>
</tr>
<tr>
<td>29-1123</td>
<td>Physical Therapists</td>
</tr>
<tr>
<td>29-1124</td>
<td>Radiation Therapists</td>
</tr>
<tr>
<td>29-1125</td>
<td>Recreational Therapists</td>
</tr>
<tr>
<td>29-1126</td>
<td>Respiratory Therapists</td>
</tr>
<tr>
<td>29-1127</td>
<td>Speech-Language Pathologists</td>
</tr>
<tr>
<td>29-1128</td>
<td>Exercise Physiologists</td>
</tr>
<tr>
<td>29-1129</td>
<td>Therapists, All Other</td>
</tr>
<tr>
<td>29-1141</td>
<td>Registered Nurses</td>
</tr>
<tr>
<td>29-1151</td>
<td>Nurse Anesthetists</td>
</tr>
<tr>
<td>29-1161</td>
<td>Nurse Midwives</td>
</tr>
<tr>
<td>29-1171</td>
<td>Nurse Practitioners</td>
</tr>
<tr>
<td>29-1181</td>
<td>Audiologists</td>
</tr>
<tr>
<td>29-1199</td>
<td>Health Diagnosing and Treating Practitioners, All Other</td>
</tr>
<tr>
<td>29-2021</td>
<td>Dental Hygienists</td>
</tr>
<tr>
<td>29-2031</td>
<td>Cardiovascular Technologists and Technicians</td>
</tr>
<tr>
<td>29-2032</td>
<td>Diagnostic Medical Sonographers</td>
</tr>
<tr>
<td>29-2033</td>
<td>Nuclear Medicine Technologists</td>
</tr>
<tr>
<td>29-2034</td>
<td>Radiologic Technologists</td>
</tr>
<tr>
<td>29-2035</td>
<td>Magnetic Resonance Imaging Technologists</td>
</tr>
<tr>
<td>29-2041</td>
<td>Emergency Medical Technicians and Paramedics</td>
</tr>
<tr>
<td>29-2051</td>
<td>Dietetic Technicians</td>
</tr>
<tr>
<td>29-2053</td>
<td>Psychiatric Technicians</td>
</tr>
<tr>
<td>29-2054</td>
<td>Respiratory Therapy Technicians</td>
</tr>
<tr>
<td>29-2055</td>
<td>Surgical Technologists</td>
</tr>
<tr>
<td>29-2057</td>
<td>Ophthalmic Medical Technicians</td>
</tr>
<tr>
<td>29-2061</td>
<td>Licensed Practical and Licensed Vocational Nurses</td>
</tr>
<tr>
<td>29-2081</td>
<td>Opticians, Dispensing</td>
</tr>
<tr>
<td>29-2091</td>
<td>Orthotists and Prosthetists</td>
</tr>
<tr>
<td>29-2092</td>
<td>Hearing Aid Specialists</td>
</tr>
<tr>
<td>29-2099</td>
<td>Health Technologists and Technicians, All Other</td>
</tr>
<tr>
<td>29-9092</td>
<td>Genetic Counselors</td>
</tr>
</tbody>
</table>
Table B-2, continued. Direct Patient/Client/Resident Care Occupations

<table>
<thead>
<tr>
<th>BLS Occupation Code, detailed</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>29-9099</td>
<td>Healthcare Practitioners and Technical Workers, All Other</td>
</tr>
<tr>
<td>31-1011</td>
<td>Home Health Aides</td>
</tr>
<tr>
<td>31-1013</td>
<td>Psychiatric Aides</td>
</tr>
<tr>
<td>31-1014</td>
<td>Nursing Assistants</td>
</tr>
<tr>
<td>31-1015</td>
<td>Patient Care Assistants</td>
</tr>
<tr>
<td>31-2011</td>
<td>Occupational Therapy Assistants</td>
</tr>
<tr>
<td>31-2012</td>
<td>Occupational Therapy Aides</td>
</tr>
<tr>
<td>31-2021</td>
<td>Physical Therapist Assistants</td>
</tr>
<tr>
<td>31-2022</td>
<td>Physical Therapist Aides</td>
</tr>
<tr>
<td>31-9011</td>
<td>Massage Therapists</td>
</tr>
<tr>
<td>31-9091</td>
<td>Dental Assistants</td>
</tr>
<tr>
<td>31-9092</td>
<td>Medical Assistants</td>
</tr>
<tr>
<td>31-9097</td>
<td>Phlebotomists</td>
</tr>
<tr>
<td>31-9099</td>
<td>Healthcare Support Workers, All Other</td>
</tr>
<tr>
<td>33-2011</td>
<td>Firefighters</td>
</tr>
<tr>
<td>33-3012</td>
<td>Correctional Officers and Jailers</td>
</tr>
<tr>
<td>39-9021</td>
<td>Personal Care Aides</td>
</tr>
<tr>
<td>39-9099</td>
<td>Personal Care and Service Workers, All Other</td>
</tr>
<tr>
<td>53-3011</td>
<td>Ambulance Drivers and Attendants, Except Emergency Medical Technicians</td>
</tr>
</tbody>
</table>


Table B-3 Direct Patient/Client/Resident Contact Occupations

<table>
<thead>
<tr>
<th>BLS Occupation Code, detailed</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>33-9032</td>
<td>Security Guards</td>
</tr>
<tr>
<td>33-9099</td>
<td>Protective Service Workers, All Other</td>
</tr>
<tr>
<td>35-2012</td>
<td>Cooks, Institution and Cafeteria</td>
</tr>
<tr>
<td>35-2021</td>
<td>Food Preparation Workers</td>
</tr>
<tr>
<td>35-3041</td>
<td>Food Servers, Non-restaurant</td>
</tr>
<tr>
<td>35-9011</td>
<td>Dining Room and Cafeteria Attendants and Bartender Helpers</td>
</tr>
<tr>
<td>37-2011</td>
<td>Janitors and Cleaners, Except Maids and Housekeeping Cleaners</td>
</tr>
<tr>
<td>37-2012</td>
<td>Maids and Housekeeping Cleaners</td>
</tr>
<tr>
<td>37-2019</td>
<td>Building Cleaning Workers, All Other</td>
</tr>
<tr>
<td>39-9041</td>
<td>Residential Advisors</td>
</tr>
</tbody>
</table>


Table B-4 Supervisory Occupations
<table>
<thead>
<tr>
<th>BLS Occupation Code</th>
<th>Occupation</th>
<th>Patient Care Supervisor</th>
<th>Patient Contact Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-1021</td>
<td>General and Operations Managers</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>11-9111</td>
<td>Medical and Health Services Managers</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>11-9161</td>
<td>Emergency Management Directors</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>11-9199</td>
<td>Managers, All Other</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>11-9051</td>
<td>Food Service Managers</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>11-9151</td>
<td>Social and Community Service Managers</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>35-1012</td>
<td>First-Line Supervisors of Food Preparation and Serving Workers</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>37-1011</td>
<td>First-Line Supervisors of Housekeeping and Janitorial Workers</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>37-1012</td>
<td>First-Line Supervisors of Landscaping, Lawn Service, and Grounds-keeping Workers</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>39-1021</td>
<td>First-Line Supervisors of Personal Service Workers</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Appendix C: Workplace Violence Incident Analysis

C.1 Introduction

OSHA developed estimates of workplace violence incidents to support the analysis of costs and benefits associated with the regulatory framework. Workplace violence incidents were a key input for several parts of the analysis, including:

- Estimating costs for incident-related hazard assessments, as well as for incident-related reporting and investigation under paragraphs (d)(4)(i) and (g); and,
- Estimating the baseline risk, including the baseline number of WPV incidents and the baseline incidence rate.

The incident analysis identified four types of WPV incidents, partly reflecting availability of data as well as the regulatory framework’s definition of a WPV incident that includes threat of physical assault:

- **Recordable, Lost-Workday**
- **Recordable, Non-Lost-Workday (more than first-aid)**
- **Other Physical (up to first-aid)**
- **Threats**

Recordable incidents are all cases in the BLS’ Survey of Occupational Injuries and Illnesses (SOII), which in turn are based on OSHA 300 logs of workplace incidents whose severity require more than first aid. (BLS 2021). Lost-work day injuries are a subset of recordable injuries, where the incident leads to days away from work for the injured person. Other (lesser) physical incidents that would be incidents under the definitions of this regulatory framework are not recorded and not part of SOII data. Similarly, threats are not recorded in OSHA 300 logs but are covered under this regulatory framework. OSHA estimates the number of each type of incident based primarily on incident data published by BLS, and extrapolations based on this data. For the purposes of costing, OSHA conservatively does not account for the potential effect of the potential rule in reducing WPV incidents. In other words, the cost analysis of the draft regulatory framework assumes the same number of incidents that occur currently, in the absence of an OSHA rule.

All incident estimates presented below are developed at the NAICS industry-ownership-size level.

C.2 WPV Lost Workday Injuries and Illnesses

Lost-work day injuries in the private sector are obtained from the BLS’ 2019 SOII incident statistics giving the number, incidence rate, and median days away from work associated with different types of occupational injuries and illnesses (BLS 2021). These data are specified primarily at the 4-digit NAICS industry level.

OSHA’s methodology is the following. First, the agency estimated incidence rates for each NAICS industry based on the 4-digit NAICS industry sectors for which rates were available. Incidence rates given in the SOII are in units of incidents-per-10,000 full time equivalent (FTE)
worker, where an FTE employee works 40 hours per week for 50 weeks per year. Data on lost-work time injuries include more detailed information about the circumstances involved than other kinds of injuries, including a coding of event type. Incidence rates are included for two event types of WPV lost-work day incidents in the SOII data: *Intentional injury by other person*; and, *Injury by person-unintentional or intent unknown*. With respect to unintentional injuries, OSHA was specifically interested in a subset of that category, namely, *Injured by physical contact with person while restraining-subduing—unintentional*.

To estimate state and local government incidence rates, OSHA applied additional assumptions. The more detailed SOII 2019 data with event type include state and local government incidence rates for only two NAICS industries: general hospitals, and nursing care facilities. OSHA began with these state and local rates and then estimated state and local rates for other NAICS industries based on the relationship between public and private rates for general hospitals, and the private rates for all other NAICS industries. Table C-1 through Table C-3 present lost-workday incidence rates, per 10,000 FTE employees, estimated from the BLS data, for private, state, and local government facilities, by industry.

41 OSHA used the public General Hospital and Nursing Care facility rates directly for those two NAICS industries. For other NAICS industry X, Public rate_X = Private rate_X * (Public rate_Hospital / Private rate_Hospital). This adjustment assumes that whatever systemic factors drive the difference in public/private rates of violence incidents in hospitals (differences in facilities, population mix, etc.) also proportionately affect rates in the other affected industries. The ratio of State government-to-private in General Hospitals is 11 for intentional injuries; for Local government-to-private the ratio is 1.6. The ratios applied to Nursing Homes, the other possible choice for this adjustment, are identical to those for general hospitals.
## Table C-1. Private Lost Workday Incidence Rates (incidents per 10,000 FTEs)

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Intentional Injury by Other Person</th>
<th>Injured by physical contact while restraining—unintentional</th>
<th>Total WPV Lost-Work Day Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>26.6</td>
<td>0.0</td>
<td>26.6</td>
</tr>
<tr>
<td>621300</td>
<td>Offices of other health practitioners</td>
<td>10.5</td>
<td>2.6</td>
<td>13.1</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>3.9</td>
<td>0.4</td>
<td>4.3</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>3.9</td>
<td>0.4</td>
<td>4.3</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>4.1</td>
<td>-</td>
<td>4.1</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>3.4</td>
<td>2.2</td>
<td>5.6</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>9.7</td>
<td>2.4</td>
<td>12.1</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>124.9</td>
<td>42.8</td>
<td>167.7</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>12.8</td>
<td>3.9</td>
<td>16.7</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>14.9</td>
<td>0.3</td>
<td>15.2</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual, Developmental Disability</td>
<td>41.7</td>
<td>11.5</td>
<td>53.2</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>41.7</td>
<td>11.5</td>
<td>53.2</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>8.5</td>
<td>0.7</td>
<td>9.2</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>8.5</td>
<td>0.7</td>
<td>9.2</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>61</td>
<td>29</td>
<td>90.0</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>29.2</td>
<td>6.9</td>
<td>36.1</td>
</tr>
<tr>
<td>624120</td>
<td>Services for Elderly and Persons with Disabilities</td>
<td>14.7</td>
<td>0.5</td>
<td>15.2</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>7.6</td>
<td>1.1</td>
<td>8.7</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>7.5</td>
<td>-</td>
<td>7.5</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>11.8</td>
<td>-</td>
<td>11.80</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>11.8</td>
<td>-</td>
<td>11.80</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>7.5</td>
<td>-</td>
<td>7.50</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>17</td>
<td>1.7</td>
<td>18.70</td>
</tr>
<tr>
<td></td>
<td>Firefighter-EMTs</td>
<td>2</td>
<td>1.3</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Note: A “-” means the statistic does not meet BLS standards for publication (see [https://www.bls.gov/opub/hom/soii/presentation.htm](https://www.bls.gov/opub/hom/soii/presentation.htm), Publication guidelines for SOII estimates. OSHA assigned these case rates a value of zero.)
## Table C-2. State Government Lost Workday Incidence Rates (incidents per 10,000 FTEs)

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Intentional Injury by Other Person</th>
<th>Injured by physical contact while restraining—unintentional</th>
<th>Total WPV Lost-Work Day Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>9</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>34</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>42</td>
<td>9</td>
<td>52</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>42</td>
<td>9</td>
<td>52</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>45</td>
<td>-</td>
<td>45</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>37</td>
<td>51</td>
<td>88</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>105</td>
<td>55</td>
<td>161</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>1,357</td>
<td>984</td>
<td>2,342</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>139</td>
<td>90</td>
<td>229</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>136</td>
<td>52</td>
<td>189</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual, Developmental Disability</td>
<td>453</td>
<td>265</td>
<td>718</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>453</td>
<td>265</td>
<td>718</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>92</td>
<td>16</td>
<td>108</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>92</td>
<td>16</td>
<td>108</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>663</td>
<td>667</td>
<td>1,330</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>317</td>
<td>159</td>
<td>476</td>
</tr>
<tr>
<td>624120</td>
<td>Services for Elderly and Persons with Disabilities</td>
<td>160</td>
<td>12</td>
<td>171</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>83</td>
<td>25</td>
<td>108</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>81</td>
<td>-</td>
<td>81</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>128</td>
<td>-</td>
<td>128</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>128</td>
<td>-</td>
<td>128</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>81</td>
<td>-</td>
<td>81</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>185</td>
<td>39</td>
<td>224</td>
</tr>
<tr>
<td></td>
<td>Firefighter-EMTs</td>
<td>22</td>
<td>30</td>
<td>52</td>
</tr>
</tbody>
</table>

Source: OSHA, 2023, based on BLS (2020-2021).
Note: A “-” means the statistic does not meet BLS standards for publication (see [https://www.bls.gov/opub/hom/soti/presentation.htm](https://www.bls.gov/opub/hom/soti/presentation.htm), Publication guidelines for SOII estimates). OSHA assigned these case rates a value of zero.
<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Intentional Injury by Other Person</th>
<th>Injured by physical contact while restraining--unintentional</th>
<th>Total WPV Lost-Work Day Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>1.2</td>
<td>0.2</td>
<td>1</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>4.8</td>
<td>0.2</td>
<td>5</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>6.1</td>
<td>0.5</td>
<td>7</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>6.1</td>
<td>0.5</td>
<td>7</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>6.4</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>5.3</td>
<td>2.6</td>
<td>8</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>15</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>194.4</td>
<td>49.9</td>
<td>244</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>19.9</td>
<td>4.6</td>
<td>24</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>31</td>
<td>0.4</td>
<td>31</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual, Developmental Disability</td>
<td>64.9</td>
<td>13.4</td>
<td>78</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>64.9</td>
<td>13.4</td>
<td>78</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>13.2</td>
<td>0.8</td>
<td>14</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>13.2</td>
<td>0.8</td>
<td>14</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>95.0</td>
<td>33.8</td>
<td>129</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>45.5</td>
<td>8.1</td>
<td>54</td>
</tr>
<tr>
<td>624120</td>
<td>Services for Elderly and Persons with Disabilities</td>
<td>22.9</td>
<td>0.6</td>
<td>23</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>11.8</td>
<td>1.3</td>
<td>13</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>11.7</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>18.4</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>18.4</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>11.7</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>26.5</td>
<td>2.0</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Firefighter-EMTs</td>
<td>3.1</td>
<td>1.5</td>
<td>5</td>
</tr>
</tbody>
</table>

Note: A “-” means the statistic does not meet BLS standards for publication (see https://www.bls.gov/opub/hom/soii/presentation.htm. Publication guidelines for SOII estimates. OSHA assigned these case rates a value of zero.

Next, OSHA multiplied these rates by the number of potentially regulated employees, by ownership and NAICS, to estimate the number of recorded lost workday WPV incidents. This step also required accounting for the fact that not every employee in the industry profile is a full-time employee, as is used in the SOII definition of the incidence rates. OSHA obtained data describing the average hours worked per week for employees from BLS’ Current Employment Statistics survey (BLS 2020b), by NAICS code for 2015 to 2018. These data indicate that employees overall work an average of between 27.0 – 38.4 hours per week, as shown in Table C-4. When applying BLS incidence rates per 10,000 FTE employees, OSHA estimated the number of FTE-equivalent employees by multiplying the number of covered employees by the percentages presented in Table C-4.
As discussed in the Why Regulation is Being Considered section, numerous studies suggest that WPV incidents are under-reported in the healthcare sector. To correct for this error, OSHA assumed that recorded lost workday incidents represent 85 percent of all potentially recordable lost-work day incidents, including unreported incidents. This eighty-five percent estimate is based on agency judgment and may be inaccurate. This adjustment increases incidents by eighteen percent ((reported incidents / 0.85) = 1.18 * reported incidents). Based on this adjustment, the incidence rates, covered employees, and the FTE adjustment, OSHA estimated the resulting number of lost-workday WPV incidents, by NAICS, ownership, and facility size, shown by size and setting in Table C-6, below.

### C.3 Recordable Non-Lost Workday Injuries, and Other WPV Incidents

#### Table C-4. Number of Reported Average Hours Worked per Employee per Week

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Per Employee Hours Worked</th>
<th>Ratio to FTE (40 hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>30.6</td>
<td>77%</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td>27</td>
<td>68%</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td>34.2</td>
<td>86%</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical and Emergency Centers</td>
<td>31.2</td>
<td>78%</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>28.5</td>
<td>71%</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>36.2</td>
<td>91%</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>37.5</td>
<td>94%</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>34.8</td>
<td>87%</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty (except Psychiatric and Substance Abuse) Hospitals</td>
<td>34.6</td>
<td>87%</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>33</td>
<td>83%</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual and Developmental Disability Facilities</td>
<td>34.6</td>
<td>87%</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse Facilities</td>
<td>35.3</td>
<td>88%</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>32.4</td>
<td>81%</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>33.2</td>
<td>83%</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>35.4</td>
<td>89%</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>32.1</td>
<td>80%</td>
</tr>
<tr>
<td>624120</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>28.4</td>
<td>71%</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>32.3</td>
<td>81%</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>35.5</td>
<td>89%</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>33.6</td>
<td>84%</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>33.6</td>
<td>84%</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>34</td>
<td>85%</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>30.9</td>
<td>77%</td>
</tr>
<tr>
<td>561990</td>
<td>Fire Protection</td>
<td>36.2</td>
<td>91%</td>
</tr>
</tbody>
</table>

Source: OSHA, 2023, based on BLS (2020b).
Next, OSHA estimated the number of recordable, non-lost-workday WPV injuries. As stated above, for recorded injuries with no lost work days, the SOII does not give detailed information on the incident, including whether or not it was due to WPV. From the data, the share of lost-workday WPV incidents among all lost-workday incidents can be calculated. Assuming this same WPV share holds for recordable non-lost-workday injuries, which implies the same share for the total combining the two, OSHA derived an estimate based on the following:

- OSHA obtained BLS incidence rates for total recordable and total lost-workday, nonfatal occupational injuries and illnesses (BLS 2021), by NAICS code.

- These incidence rates were used to calculate the ratio of total recordable to total lost-work day incidents, as shown in Table C-5.

**Table C-5. BLS Ratio of Total Recordable to Lost-Work Incidents**

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Ratio of Total Recordable to Total Lost-Work Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>3.19</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners</td>
<td>4.56</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>4.84</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>4.84</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>2.39</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>2.63</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>4.18</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>2.68</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>2.96</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>3.30</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual, Developmental Disability</td>
<td>3.24</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>3.24</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>3.78</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>3.78</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>2.90</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>2.97</td>
</tr>
<tr>
<td>624120</td>
<td>Services for Elderly and Persons with Disabilities</td>
<td>2.51</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>2.86</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>3.30</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>2.95</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>2.95</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>3.30</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>3.15</td>
</tr>
<tr>
<td></td>
<td>Firefighter-EMTs</td>
<td>2.99</td>
</tr>
</tbody>
</table>


The total recordable WPV incidents comprise those resulting in lost-work days and those not resulting in lost-work days (or non-lost-workday incidents). The ratio of total recordable WPV
incidents to recordable lost-work day incidents, presented in Table C-5, is total recordable WPV incidents divided by lost-work day incidents. Total recordable WPV incidents per NAICS industry is the number of recordable lost-work day incidents multiplied by that ratio. Recordable non-lost-workday incidents can then be calculated as the total recordable WPV incidents minus the recordable lost-work day incidents. See Appendix C Addendum for an example of how OSHA derived these estimates.

Next, OSHA, based on professional judgment, estimated that the number of incidents of other physical injuries and threats covered by the draft rule is equal to 150 percent of total recordable WPV incidents. Less severe injuries, not required to be reported on OSHA logs, may occur frequently and yet receive less attention and formal reporting. Hence, OSHA included this category of incidents in the baseline risk profile.

C.4 Total WPV Incidents and Incidents-per-Facility

Table C-6 presents OSHA’s estimates of the number of WPV incidents at establishments in scope of the draft regulatory framework, annually, by healthcare setting and size. As shown in the addendum to this appendix, Step 10, OSHA summed WPV recordable lost-work day incidents and WPV recordable non-lost-work day incidents to estimate total WPV recordable incidents. To account for the underreporting of WPV incidents, OSHA estimated that the number of other WPV physical incidents and other WPV threat incidents are each one and one-half times the number of total WPV recordable incidents. The figures calculated through that methodology were then summed across NAICS industries, by entity size, to estimate the total recordable incidents and non-recordable incidents (other physical threats, and other threat incidents), by healthcare setting, shown in Table C-6.

OSHA estimates approximately 150,000 total recordable incidents per year and an overall total of 600,000 cases when non-recordable incidents are included.

### Table C-6. WPV Incidents per Year, by Healthcare Setting and Facility Size

<table>
<thead>
<tr>
<th>Setting and Size</th>
<th>WPV Recordable, Lost-Work Incidents</th>
<th>WPV Recordable, Non-Lost-Work Incidents</th>
<th>Total Recordable WPV Incidents</th>
<th>Other Physical Incidents</th>
<th>Other Threat Incidents</th>
<th>Total WPV Incidents (recordable and non-recordable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Settings</td>
<td>49,440</td>
<td>105,312</td>
<td>154,752</td>
<td>238,128</td>
<td>223,128</td>
<td>619,008</td>
</tr>
<tr>
<td>Large</td>
<td>41,151</td>
<td>87,695</td>
<td>128,846</td>
<td>193,269</td>
<td>193,269</td>
<td>515,384</td>
</tr>
<tr>
<td>Small</td>
<td>8,289</td>
<td>17,618</td>
<td>25,906</td>
<td>38,859</td>
<td>38,859</td>
<td>103,624</td>
</tr>
<tr>
<td>Very Small</td>
<td>1,191</td>
<td>2,453</td>
<td>3,644</td>
<td>5,466</td>
<td>5,466</td>
<td>14,576</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>28,079</td>
<td>51,986</td>
<td>80,066</td>
<td>120,099</td>
<td>120,099</td>
<td>320,263</td>
</tr>
<tr>
<td>Large</td>
<td>25,235</td>
<td>45,721</td>
<td>70,957</td>
<td>106,435</td>
<td>106,435</td>
<td>283,826</td>
</tr>
<tr>
<td>Small</td>
<td>2,844</td>
<td>6,265</td>
<td>9,109</td>
<td>13,664</td>
<td>13,664</td>
<td>36,437</td>
</tr>
<tr>
<td>Very Small</td>
<td>353</td>
<td>819</td>
<td>1,171</td>
<td>1,757</td>
<td>1,757</td>
<td>4,685</td>
</tr>
<tr>
<td>Other Hospitals (excluding BH)</td>
<td>10,051</td>
<td>30,662</td>
<td>40,714</td>
<td>61,071</td>
<td>61,071</td>
<td>162,855</td>
</tr>
<tr>
<td>Large</td>
<td>9,582</td>
<td>29,189</td>
<td>38,772</td>
<td>58,157</td>
<td>58,157</td>
<td>155,086</td>
</tr>
</tbody>
</table>
### Table C-7. WPV Incidents per Facility, Large Facilities, all Ownerships

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Recordable WPV Incidents</th>
<th>Non-Recordable WPV Incidents</th>
<th>Total Incidents per Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lost-Work</td>
<td>Non-Lost-Work</td>
<td>Other Physical</td>
</tr>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>0.01</td>
<td>0.03</td>
<td>0.07</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (excl. Physicians)</td>
<td>0.02</td>
<td>0.08</td>
<td>0.15</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>0.02</td>
<td>0.07</td>
<td>0.13</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory and Emergency Centers</td>
<td>0.01</td>
<td>0.04</td>
<td>0.08</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>0.03</td>
<td>0.04</td>
<td>0.10</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>0.03</td>
<td>0.04</td>
<td>0.10</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>2.2</td>
<td>7.0</td>
<td>13.9</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>15.3</td>
<td>25.7</td>
<td>61.5</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty (except Psychiatric, Substance Abuse) Hospitals</td>
<td>1.37</td>
<td>2.69</td>
<td>6.08</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>0.20</td>
<td>0.45</td>
<td>0.97</td>
</tr>
</tbody>
</table>

Source: OSHA, 2023, based on BLS (2021) and BLS (2020b).  
Note: Very Small is a subset of SBA-defined Small.

Tables C-7 through C-9 summarize average annual number of WPV incidents per facility, for large, small, and very small facilities, respectively. The values presented here are aggregated on a facility-weighted basis across all ownership categories for presentation, but the analysis itself uses separate estimates by ownership.

Table C-7., WPV Incidents per Facility, Large Facilities, all Ownerships
<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Recordable WPV Incidents</th>
<th>Non-Recordable WPV Incidents</th>
<th>Total Incidents per Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (excl. Physicians)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>0.01</td>
<td>0.03</td>
<td>0.06</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory and Emergency Centers</td>
<td>0.01</td>
<td>0.02</td>
<td>0.04</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>0.01</td>
<td>0.01</td>
<td>0.03</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>0.02</td>
<td>0.03</td>
<td>0.07</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>0.29</td>
<td>0.91</td>
<td>1.80</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>2.91</td>
<td>4.90</td>
<td>11.71</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty (except Psychiatric, Substance Abuse) Hospitals</td>
<td>0.20</td>
<td>0.39</td>
<td>0.88</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>0.12</td>
<td>0.29</td>
<td>0.62</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual and Developmental Disability</td>
<td>0.09</td>
<td>0.19</td>
<td>0.42</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>0.12</td>
<td>0.27</td>
<td>0.59</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>0.06</td>
<td>0.15</td>
<td>0.32</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>0.01</td>
<td>0.04</td>
<td>0.08</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>0.19</td>
<td>0.37</td>
<td>0.84</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>0.05</td>
<td>0.09</td>
<td>0.21</td>
</tr>
<tr>
<td>624120</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>0.03</td>
<td>0.05</td>
<td>0.12</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>0.01</td>
<td>0.02</td>
<td>0.04</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>0.01</td>
<td>0.01</td>
<td>0.03</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>0.02</td>
<td>0.04</td>
<td>0.10</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>0.01</td>
<td>0.03</td>
<td>0.06</td>
</tr>
</tbody>
</table>

Source: OSHA, 2023, based on BLS (2021) and BLS (2020b).
* By definition (see Section 1.4, above), there are no large Temporary Shelters.
<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Recordable WPV Incidents</th>
<th>Non-Recordable WPV Incidents</th>
<th>Total Incidents per Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lost-Work</td>
<td>Non-Lost-Work</td>
<td>Other Physical</td>
</tr>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (excl. Physicians)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>0.00</td>
<td>0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory and Emergency Centers</td>
<td>0.00</td>
<td>0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>0.00</td>
<td>0.00</td>
<td>0.01</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>0.00</td>
<td>0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>0.00</td>
<td>0.02</td>
<td>0.03</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>0.16</td>
<td>0.27</td>
<td>0.64</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty (except Psychiatric, Substance Abuse) Hospitals</td>
<td>0.01</td>
<td>0.02</td>
<td>0.04</td>
</tr>
<tr>
<td>623110</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>0.01</td>
<td>0.02</td>
<td>0.03</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual and Developmental Disability</td>
<td>0.06</td>
<td>0.14</td>
<td>0.31</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>0.04</td>
<td>0.09</td>
<td>0.20</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>0.01</td>
<td>0.02</td>
<td>0.03</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>0.00</td>
<td>0.01</td>
<td>0.03</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>0.11</td>
<td>0.20</td>
<td>0.46</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>0.03</td>
<td>0.06</td>
<td>0.15</td>
</tr>
<tr>
<td>624120</td>
<td>Services for the Elderly and Persons with Disabilities</td>
<td>0.01</td>
<td>0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>0.01</td>
<td>0.01</td>
<td>0.03</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>0.00</td>
<td>0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>0.01</td>
<td>0.02</td>
<td>0.04</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>0.01</td>
<td>0.01</td>
<td>0.03</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>0.00</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>624310</td>
<td>Vocational Rehabilitation Services</td>
<td>0.01</td>
<td>0.02</td>
<td>0.05</td>
</tr>
<tr>
<td>624310</td>
<td>Firefighter-EMTs</td>
<td>0.01</td>
<td>0.01</td>
<td>0.03</td>
</tr>
</tbody>
</table>

Source: OSHA, 2023, based on BLS (2021) and BLS (2020b).
Note: All values are greater than zero but may appear as zero due to rounding.

C.5 Incidents Per-Facility, by Ownership

Table C-10 through Table C-13 present the estimated total number of WPV incidents per facility per year, by ownership category: for-profit, non-profit, state government, and local government establishments, respectively. These data are key inputs for the analyses of unit costs for the regulatory framework’s various provisions.
**Table C-10. Total WPV Incidents per Facility, For-Profit**

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Total WPV Incidents per Facility</th>
<th>Large</th>
<th>Small</th>
<th>Very Small</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td></td>
<td>-</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td></td>
<td>-</td>
<td>0.02</td>
<td>0.01</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td></td>
<td>0.18</td>
<td>0.10</td>
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### Table C-11. Total WPV Incidents per Facility, Non-Profit

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Total WPV Incidents per Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Large</td>
</tr>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
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</tr>
<tr>
<td>621330</td>
<td>Offices of Mental Health Practitioners (except Physicians)</td>
<td>-</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse Centers</td>
<td>0.38</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical and Emergency Centers</td>
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</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>0.47</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
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<td>Psychiatric and Substance Abuse Hospitals</td>
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</tr>
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<td>Other Community Housing Services</td>
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<td>Firefighter-EMTs</td>
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<td>Other Community Housing Services</td>
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<td>624230</td>
<td>Emergency and Other Relief Services</td>
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<th>Total WPV Incidents per Facility</th>
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<tr>
<td>621910</td>
<td>Ambulance Services</td>
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Appendix C Addendum: Descriptions of Data and Calculations for WPV Incident Analysis

This document presents the data sources and step-by-step calculation for one 6-digit NAICS industry (622210 - Psychiatric and Substance Abuse Hospitals) for the WPV Incident Analysis leading up to Table C-6 (WPV Incidents per Year, by Healthcare Setting and Facility Size). Some of the calculated values presented may not sum due to rounding.

Data Sources

The following source data for NAICS code 622210 were used in the calculations:

<table>
<thead>
<tr>
<th>NAICS Code</th>
<th>Description (NAICS codes for industries)</th>
<th>Ownership</th>
<th>Event or Exposure</th>
<th>Incidence Rate</th>
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<tbody>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>Private</td>
<td>111 Intentional injury by other person</td>
<td>124.9</td>
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<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>Private</td>
<td>1214 Injured by physical contact with person while restraining-subduing--unintentional</td>
<td>42.8</td>
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<tr>
<td>622000</td>
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<td>Private</td>
<td>111 Intentional injury by other person</td>
<td>9.7</td>
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<td>Hospitals</td>
<td>State Government</td>
<td>111 Intentional injury by other person</td>
<td>105.4</td>
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<td>622000</td>
<td>Hospitals</td>
<td>Local Government</td>
<td>111 Intentional injury by other person</td>
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<tr>
<td>622000</td>
<td>Hospitals</td>
<td>Private</td>
<td>1214 Injured by physical contact with person while restraining-subduing--unintentional</td>
<td>2.4</td>
</tr>
<tr>
<td>622000</td>
<td>Hospitals</td>
<td>State Government</td>
<td>1214 Injured by physical contact with person while restraining-subduing--unintentional</td>
<td>55.2</td>
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<tr>
<td>622000</td>
<td>Hospitals</td>
<td>Local Government</td>
<td>1214 Injured by physical contact with person while restraining-subduing--unintentional</td>
<td>2.8</td>
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</table>

Because BLS SOII does not report WPV incidence rates at the five- and six-digit NAICS industry level for all ownership groups and all size categories, OSHA in this addendum, estimated WPV incidence rates using the data reported by BLS SOII at the three-digit NAICS industry level, by ownership group. The reported BLS data are shown in the tables on this page and the following page. Combined with Census’s County Business Patterns data for employment by enterprise size and employment type (shown in the tables on the following page), the reported BLS SOII data enabled OSHA to estimate WPV incidence rates and the number of WPV incidents by ownership group and size category. OSHA requests public comment on the analytical methodology presented in this addendum.
### BLS Current Employment Statistics Survey – Employment, Hours, and Earnings

<table>
<thead>
<tr>
<th>NAICS Code</th>
<th>Description (NAICS codes for industries)</th>
<th>BLS NAICS</th>
<th>Hours Worked</th>
<th>Ratio to FTE</th>
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<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>621112</td>
<td>34.8</td>
<td>87%</td>
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Note: Data Extracted March 5, 2020.

#### 2017 County Business Patterns Data for NAICS Code 622210 (Psychiatric and Substance Abuse Hospitals)

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<tr>
<th>Employment Type</th>
<th>Total</th>
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</tr>
<tr>
<td>Non-profit Employees</td>
<td>40,303</td>
</tr>
<tr>
<td>Government Hospitals Employees</td>
<td>94,198</td>
</tr>
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</table>

#### 2017 County Business Patterns and 2017 Economic Census for NAICS Code 622210 (Psychiatric and Substance Abuse Hospitals)

<table>
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<th>Enterprise Employment Size</th>
<th>Employment</th>
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<tbody>
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<td>228,816</td>
</tr>
<tr>
<td>02: &lt;5</td>
<td>6</td>
</tr>
<tr>
<td>04: 10-19</td>
<td>58</td>
</tr>
<tr>
<td>05: &lt;20</td>
<td>69</td>
</tr>
<tr>
<td>06: 20-99</td>
<td>1,582</td>
</tr>
<tr>
<td>07: 100-499</td>
<td>45,392</td>
</tr>
<tr>
<td>08: &lt;500</td>
<td>47,043</td>
</tr>
<tr>
<td>09: 500+</td>
<td>181,773</td>
</tr>
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</table>

#### BLS, 2019 Incidence rates of nonfatal occupational injuries and illnesses by industry and case types (6222 - Psychiatric and substance abuse hospitals)

<table>
<thead>
<tr>
<th>Total recordable cases</th>
<th>Cases with days away from work, job restriction, or transfer</th>
<th>Other recordable cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Cases with days away from work</td>
<td>Cases with days of job transfer or restriction</td>
</tr>
<tr>
<td>7.2</td>
<td>4.1</td>
<td>2.5</td>
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</table>

Note: The incidence rates represent the number of injuries and illnesses per 100 full-time workers.

#### Step-by-Step Calculations

**Step 1. Obtain lost-work day incidence rate in private (for-profit) sector**

- From BLS 2018 SOII data, Psychiatric and Substance Abuse Hospitals reported a rate of 124.9 intentional injury by other person incidents per 10,000 FTE and 42.8 unintentional injured by physical contact with person while restraining/subduing incidents per 10,000 FTE for a total incidence rate of 167.7 recorded per 10,000 FTE.
Values are presented in Table C-1.

Please note that private incidence rates are provided for the 4-digit NAICS level, and we assume the same rates apply to the 6-digit NAICS industries.

**Step 2. Calculate incidence rates for state government entities**

- To estimate the state government incidence rates, apply the ratio of the state government general hospital rate divided by the private general hospital rate.
  - The rate of intentional injury by other person incidents for a state government general hospital is 105.4 per 10,000 FTE and the private rate is 9.7 per 10,000 FTE, yielding a ratio of 10.8 (105.4 ÷ 9.7).
  - The rate of unintentional injury by physical contact with person while restraining/subduing incidents for a state government general hospital is 55.2 per 10,000 FTE and the private rate is 2.4 per 10,000 FTE, yielding a ratio of 22.9 (55.2 ÷ 2.4).
- To estimate the state government incidence rates for Psychiatric and Substance Abuse Hospitals, multiply the private rates for each event type and then sum the two results.
  - The rate of intentional injury in a state Psychiatric and Substance Abuse Hospital is estimated to be 1,357.2 per 10,000 FTE (124.9 x 10.8).
  - The rate of unintentional injury by physical contact with person while restraining/subduing incidents in a state Psychiatric and Substance Abuse Hospital is estimated to be 984.4 per 10,000 FTE (42.8 x 22.9).
  - Summed, the total incidence rate for state government Psychiatric and Substance Abuse Hospitals with days away from work is estimated to be 2,341.6 (1,357.2 + 984.4).
- Values are presented in Table C-2.

**Step 3. Calculate incidence rates for Local Government entities**

- Step 3 repeats Step 2 apart from using the ratio of the local government general hospital rate divided by the private general hospital rate.
  - The rate of intentional injury by other person incidents for a local government general hospital is 15.1 per 10,000 FTE and the private rate is 9.7 per 10,000 FTE, yielding a ratio of 1.6 (15.1 ÷ 9.7).
  - The rate of unintentional injury by physical contact with person while restraining/subduing incidents for a local government general hospital is 2.8 per 10,000 FTE and the private rate is 2.4 per 10,000 FTE, yielding a ratio of 1.2 (2.8 ÷ 2.4).
- To estimate the local government incidence rates for Psychiatric and Substance Abuse Hospitals, multiply the private rates for each event type and then sum the two results.
  - The rate of intentional injury in a local Psychiatric and Substance Abuse Hospital is estimated to be 194.4 per 10,000 FTE (124.9 x 1.6).
  - The rate of unintentional injury by physical contact with person while restraining/subduing incidents in a local government Psychiatric and Substance Abuse Hospital is estimated to be 49.9 per 10,000 FTE (42.8 x 1.2).
Summed, the total incidence rate for local government Psychiatric and Substance Abuse Hospitals with days away from work is estimated to be 244.4 (194.4 + 49.9).
- Values are presented in Table C-3.

**Step 4. Obtain average weekly hours worked (BLS’ Current Employment Statistics survey)**
- As not all employees are FTEs and the rates estimated in Steps 1, 2, and 3 are per FTE, all employees must be accounted for.
  - Obtain data describing the average hours worked per week for employees from BLS’ Current Employment Statistics survey by NAICS code for 2015 to 2018.
  - The average weekly hours worked in Psychiatric and Substance Abuse Hospitals was 34.8 hours, or 87 percent of the hours for an FTE.
- Values are presented in Table C-4.

**Step 5. Estimate the number of employees for large entities**
- Estimate total private employment:
  - According to US Census Bureau 2017 County Business Pattern data, Psychiatric and Substance Abuse Hospitals employed a total of 228,816 people.
  - Subtract 94,198 employed by Government Hospitals (LFO: G).
  - Total private (for-profit) Psychiatric and Substance Abuse Hospital employment is estimated to be 94,315 (228,816 - 40,303 – 94,198).
- Estimate SBA-defined small private employment:
  - According to US Census Bureau 2017 County Business Pattern and 2017 Economic Census data, SBA-defined small Psychiatric and Substance Abuse Hospitals employed a total of 47,038 people.
  - Subtract the estimated SBA-defined small non-profit employees: 8,285 people.
    - The SBA-defined small non-profit employees are estimated as scaled to reflect the SBA-defined small portion of the total employment for Psychiatric and Substance Abuse Hospitals. In other words, the total SBA-defined small employment is multiplied by the total non-profit employees, divided by the total employees.
    - The equation: 8,285 people = 47,038 x (40,303 ÷ 228,816)
  - Subtract the estimated 19,364 employed by SBA-defined small Government Hospitals.
    - The SBA-defined small government employees are estimated as scaled to reflect the SBA-defined portion of the total employment for Psychiatric and Substance Abuse Hospitals. In other words, the total SBA-defined small employment is multiplied by the total government employees, divided by the total employees.
    - The equation: 19,364 people = 47,038 x (94,198 ÷ 228,816)
  - Total private Psychiatric and Substance Abuse Hospital employment is estimated to be 19,388 (47,038 - 8,285 – 19,364).
- Total private employment for large entities is the SBA-defined small private employment subtracted from the total private employment, or 74,927 (94,315 – 19,388).

**Step 6. Estimate number of recordable lost-workday WPV incidents, large-private facilities**

- To estimate the number of reported/investigated incidents:
  - First, take the total rate calculated in Step 1 and presented in Table C-1 (167.7 recorded per 10,000 FTE).
  - Next scale to total employees in large-private facilities
    - Multiply it by the total employees (74,927),
    - Multiply by the average weekly hours worked (Step 4 and Table C-4), and
    - Divide by 10,000 for consistent units.
  - Equation: 167.7 x (74,927 x 87% ÷ 10,000) = 1,093.2 reported/investigated incidents.
- To correct for the under-reporting of WPV incidents in the healthcare sector error, multiply the number of reported/investigated incidents by (1 ÷ 0.85) (described in Section C.2).
  - 1,093.2 x (1 ÷ 0.85) = 1,286.1 total recordable, WPV, lost-work incidents

**Step 7. Estimate total recordable WPV incidents and recordable WPV non-lost-work incidents, large-private, for-profit facilities**

- As described in Section C.3, the total recordable WPV incidents comprises those resulting in lost-work days and those not resulting in lost-work days (or non-lost-workday incidents).
- The ratio of total recordable incidents to total lost-work incidents for psychiatric and substance abuse hospitals, 2.68, presented in Table C-5, is derives from 2019 BLS data. In 2019, psychiatric and substance abuse hospitals had a total of 7.2 recordable cases per 100 FTE, of which 2.5 cases per 100 FTE resulted in days away from work.
  - OSHA scaled both rates up by 0.3 to correct for the under-reporting of WPV incidents [0.3 = 1.68 (intentional/restrained rate 168 per 10,000 FTE) X ((1-0.85)/0.85)]
    - 7.2 + 0.3 = 7.5
    - 2.5 + 0.3 = 2.8
  - The ratio, 2.68 = 7.5 ÷ 2.8
- Total recordable WPV incidents for psychiatric and substance abuse hospitals is estimated to be 3,448 (1,286.1 total recordable, WPV, lost-work incidents x 2.68 total recordable incidents/total lost-work incidents).
- Thus recordable, WPV, non-lost-work incidents is 2,162 (3,448 total recordable – 1,286 recordable, WPV, lost-work incidents).

**Step 8. Estimate other physical incidents, large-private, for-profit facilities**

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43 TABLE 1. Incidence rates of nonfatal occupational injuries and illnesses by industry and case types, 2019 (bls.gov)
- As described in Section C.3, OSHA, based on professional judgment, estimated that the number of incidents of other physical injuries to be 150 percent of total recordable WPV incidents.
- As calculated in Step 7, large, private psychiatric and substance abuse hospitals were estimated to have experienced 3,448 total recordable WPV incidents.
- Multiplying 150% by of total recordable WPV incidents yields 5,172 other physical incidents (150% x 3,448).

**Step 9. Estimate other threat incidents, large-private, for-profit facilities**
- As described in Section C.3, OSHA, based on professional judgment, estimated that the number of incidents of other threat injuries to be 150 percent of total recordable WPV incidents.
- As calculated in Step 7, large, private psychiatric and substance abuse hospitals were estimated to have experienced 3,448 total recordable WPV incidents.
- Multiplying 150% by of total recordable WPV incidents yields 5,172 other threat incidents (150% x 3,448).

**Step 10. Sum and Categorize for large-private, for-profit facilities**
- Steps 6 through 10 yield inputs to Table C-6 for the Behavioral Health category as 622210 - Psychiatric and Substance Abuse Hospitals falls in that category.

<table>
<thead>
<tr>
<th>Setting and Size</th>
<th>WPV Recordable, Lost-Work Incidents</th>
<th>WPV Recordable, Non-Lost-Work Incidents</th>
<th>Total Recordable WPV Incidents</th>
<th>Other Physical Incidents</th>
<th>Other Threat Incidents</th>
<th>Total WPV Incidents (recordable and non-recordable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column:</td>
<td>A</td>
<td>B</td>
<td>C = A + B</td>
<td>D = C x 150%</td>
<td>E = C x 150%</td>
<td>F = C + D + E</td>
</tr>
<tr>
<td>Step:</td>
<td>Steps 1-6</td>
<td>Step 7</td>
<td>Step 7</td>
<td>Step 8</td>
<td>Step 9</td>
<td>Step 10</td>
</tr>
<tr>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>1,286</td>
<td>2,162</td>
<td>3,448</td>
<td>5,172</td>
<td>5,172</td>
<td>13,792</td>
</tr>
</tbody>
</table>

**Step 11. Repeat steps 6 through 10 for SBA-defined small and very small private, for-profit facilities**

**Step 12. Repeat steps 6 through 11 for private, non-profit and public (state and local) facilities**
Appendix D: Engineering Control Equipment Unit Costs

Table D-1 gives the unit cost prices for various control equipment used in the cost analysis. Unit prices are based on prices for a sample of comparable equipment found in the market. Further details on the sources for these unit costs are shown in Table D-2. These costs do not include the 20 percent mark-up OSHA applies for installation in the cost analysis (see Section 2.4.1).

Table D-1. Engineering and Work Practice Control Equipment Unit Costs

<table>
<thead>
<tr>
<th>Control Name</th>
<th>Small Size/Cost</th>
<th>Large Size/Cost</th>
<th>Units</th>
<th>Notes</th>
<th>Source (See Table D-2 for further details)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indoor lights</td>
<td>$250</td>
<td>$250</td>
<td>Per new indoor light fixture</td>
<td>Metalux RCG 4-4() 18.6W LED Linear Recessed Troffer</td>
<td>warehouse-lighting.com and LBClighting.com</td>
</tr>
<tr>
<td>Outdoor lights</td>
<td>$700</td>
<td>$700</td>
<td>Per new outdoor light fixture</td>
<td>ED Parking Lot Light Fixture, 4000K Color Temperature, 120 to 277VAC, Pole Mount Type</td>
<td>Grainger Industrial Supply</td>
</tr>
<tr>
<td>Circular or curved mirrors</td>
<td>$50</td>
<td>$50</td>
<td>Per mirror</td>
<td>Convex Mirror - 26” Glass, Indoor</td>
<td>Uline</td>
</tr>
<tr>
<td>Electronic access controls</td>
<td>$1,000</td>
<td>$2,000</td>
<td>Per system</td>
<td>Incl. control unit, power, 10 credentials, 1 reader</td>
<td>Dormakaba</td>
</tr>
<tr>
<td>Enclosed workstations with shatter-resistant glass</td>
<td>$250</td>
<td>$250</td>
<td>Per workstation</td>
<td>PLEXIGLASS Sheet - Acrylic Sheet - EXTRUDED (0.25” thick, 48” x 96”)</td>
<td>Professional Plastics</td>
</tr>
<tr>
<td>Deep service counters</td>
<td>$8,000</td>
<td>$8,000</td>
<td>Per counter</td>
<td>Assume 6’; 42” h; Frame = $2,380; Filler = $1,420; Exterior ladding=$2,022; Interior cladding $815; toe kick $750; back panel $485</td>
<td>Herman Miller</td>
</tr>
<tr>
<td>Opaque glass in patient rooms</td>
<td>$25</td>
<td>$25</td>
<td>Per room</td>
<td>Gila 4 ft. x 6.5 ft. Frosted Privacy Window Film</td>
<td>Home Depot</td>
</tr>
<tr>
<td>Separate rooms or areas for high-risk patients</td>
<td>$500</td>
<td>$500</td>
<td>Per room</td>
<td>Town Steel ADA-5 Point Anti-Ligature Arched Lock Series</td>
<td>Craft master hardware</td>
</tr>
<tr>
<td>Control Name</td>
<td>Small Size/Cost</td>
<td>Large Size/Cost</td>
<td>Units</td>
<td>Notes</td>
<td>Source (See Table D-2 for further details)</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>------------</td>
<td>--------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Two-way radios</td>
<td>$50</td>
<td>$50</td>
<td>Per radio</td>
<td>Midland - GXT1030VP4</td>
<td>Amazon</td>
</tr>
<tr>
<td>Paging system</td>
<td>$900</td>
<td>$3,900</td>
<td>Per system</td>
<td>Small: ALPHA TXT PAGER (6); Large: ALPHA TXT PAGER (48)</td>
<td>Pagertech.com</td>
</tr>
<tr>
<td>Paging System</td>
<td>$950</td>
<td>$2,240</td>
<td>Per system</td>
<td>SlimLine2 Pager System</td>
<td>Microframecorp.com</td>
</tr>
<tr>
<td>Personal panic devices</td>
<td>$50</td>
<td>$50</td>
<td>Per panic device</td>
<td>Supervised Long Range Transmitter DXS-LRC SST00124</td>
<td>BEC Integrated Solutions</td>
</tr>
<tr>
<td>Weapon detector, handheld</td>
<td>$150</td>
<td>$150</td>
<td>Per handheld detector</td>
<td>SuperWand</td>
<td>Garrett</td>
</tr>
<tr>
<td>CCTV System</td>
<td>$1,000</td>
<td>$8,000</td>
<td>Per system</td>
<td>Cantek PT8MPTZ2TB Powerful 8 Channel Pan/Tilt/Zoom 1080P HD Security System</td>
<td>Surveillance-Video</td>
</tr>
<tr>
<td>Locks on doors</td>
<td>$225</td>
<td>$225</td>
<td>Per lock</td>
<td>CL2255 Electronic Tubular Mortise Latch</td>
<td>CodeLocks America</td>
</tr>
</tbody>
</table>

Table D-3. Engineering and Work Practice Control Equipment, Product and Source Data

<table>
<thead>
<tr>
<th>Control Name</th>
<th>Vendor</th>
<th>Product name</th>
<th>Price per unit</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two-way radios</td>
<td>Amazon.com</td>
<td>Midland - GXT1030VP4</td>
<td>$35</td>
<td><a href="https://www.amazon.com">https://www.amazon.com</a></td>
</tr>
<tr>
<td>Two-way radios</td>
<td>Amazon.com</td>
<td>DEWALT DXFRS800</td>
<td>$65</td>
<td><a href="https://www.amazon.com">https://www.amazon.com</a></td>
</tr>
<tr>
<td>Paging System</td>
<td>Microframecorp.com</td>
<td>SlimLine2 40 Pager System</td>
<td>$2,243</td>
<td><a href="https://microframecorp.com">https://microframecorp.com</a></td>
</tr>
<tr>
<td>Paging System</td>
<td>Pagertec.com</td>
<td>ALPHA TXT PAGER (6)</td>
<td>$923</td>
<td><a href="https://pagertec.com">https://pagertec.com</a></td>
</tr>
<tr>
<td>Paging System</td>
<td>Pagertec.com</td>
<td>ALPHA TXT PAGER (12)</td>
<td>$1,313</td>
<td><a href="https://pagertec.com">https://pagertec.com</a></td>
</tr>
<tr>
<td>Paging System</td>
<td>Pagertec.com</td>
<td>ALPHA TXT PAGER (48)</td>
<td>$3,950</td>
<td><a href="https://pagertec.com">https://pagertec.com</a></td>
</tr>
<tr>
<td>Paging System</td>
<td>Pagertec.com</td>
<td>TrackStaff Paging (10)</td>
<td>$765</td>
<td><a href="https://pagertec.com">https://pagertec.com</a></td>
</tr>
<tr>
<td>Paging System</td>
<td>Pagertec.com</td>
<td>TrackStaff Paging (20)</td>
<td>$1,189</td>
<td><a href="https://pagertec.com">https://pagertec.com</a></td>
</tr>
<tr>
<td>Separate rooms or areas for high-risk patients (anti-ligature hardware)</td>
<td>craftmasterhardware.com</td>
<td>Glynn-Johnson HL6 Push/Pull Latch (Hospital Latch)</td>
<td>$169</td>
<td><a href="https://www.craftmasterhardware.com">https://www.craftmasterhardware.com</a></td>
</tr>
<tr>
<td>Separate rooms or areas for high-risk patients (anti-ligature hardware)</td>
<td>craftmasterhardware.com</td>
<td>Corbin Russwin Behavioral Health Lock Series with BHSS Trim</td>
<td>$831</td>
<td><a href="https://www.craftmasterhardware.com">https://www.craftmasterhardware.com</a></td>
</tr>
<tr>
<td>Separate rooms or areas for high-risk patients (anti-ligature hardware)</td>
<td>craftmasterhardware.com</td>
<td>Town Steel ADA-5 Point Anti-Ligature Arched Lock Series</td>
<td>$476</td>
<td><a href="https://www.craftmasterhardware.com">https://www.craftmasterhardware.com</a></td>
</tr>
<tr>
<td>Separate rooms or areas for high-risk patients (anti-ligature hardware)</td>
<td>craftmasterhardware.com</td>
<td>Town Steel ADA-Anti-Ligature Mortise Locks</td>
<td>$469</td>
<td><a href="https://www.craftmasterhardware.com">https://www.craftmasterhardware.com</a></td>
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</tbody>
</table>
## Table D-4, continued. Engineering and Work Practice Control Equipment, Product and Source

<table>
<thead>
<tr>
<th>Control Name</th>
<th>Vendor</th>
<th>Product name</th>
<th>Price per unit</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weapon detector, handheld</td>
<td>Amazon.com</td>
<td>SuperWand</td>
<td>$138</td>
<td><a href="https://www.amazon.com">https://www.amazon.com</a></td>
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<tr>
<td>Indoor lights</td>
<td>warehouse-lighting.com</td>
<td>WareLight Industrial Lighting Fixtures 4 Foot LED Direct/Indirect Grille Fixture with Steel Perforated Diffuser</td>
<td>$203</td>
<td><a href="https://www.warehouse-lighting.com">https://www.warehouse-lighting.com</a></td>
</tr>
<tr>
<td>Indoor lights</td>
<td>warehouse.com</td>
<td>WareLight Industrial Lighting Fixtures 4 Foot LED SUSPENDED LINEAR FIXTURE</td>
<td>$258</td>
<td><a href="https://www.warehouse-lighting.com">https://www.warehouse-lighting.com</a></td>
</tr>
<tr>
<td>Indoor lights</td>
<td>LBClighting.com</td>
<td>Metalux RCG 4-ft 18.6W LED Linear Recessed Troffer</td>
<td>$252</td>
<td><a href="https://www.lbclighting.com">https://www.lbclighting.com</a></td>
</tr>
<tr>
<td>Outdoor lights</td>
<td>Grainger</td>
<td>LED Parking Lot Light Fixture, 4000K Color Temperature, 120 to 277VAC, Pole Mount Type, 7573 lm</td>
<td>$763</td>
<td><a href="https://www.grainger.com">https://www.grainger.com</a></td>
</tr>
<tr>
<td>Outdoor lights</td>
<td>Grainger</td>
<td>LED Parking Lot Light Fixture, 4000K Color Temperature, 120 to 277VAC, Pole Mount Type</td>
<td>$633</td>
<td><a href="https://www.grainger.com">https://www.grainger.com</a></td>
</tr>
<tr>
<td>Outdoor lights</td>
<td>Grainger</td>
<td>LED Parking Lot Light Fixture, 5000K Color Temperature, 120 to 277VAC, Pole Mount Type</td>
<td>$1,924</td>
<td><a href="https://www.grainger.com">https://www.grainger.com</a></td>
</tr>
<tr>
<td>Circular or curved mirrors</td>
<td>Uline.com</td>
<td>Convex Mirror - 12” Glass, Indoor</td>
<td>$30</td>
<td><a href="https://www.uline.com">https://www.uline.com</a></td>
</tr>
<tr>
<td>Circular or curved mirrors</td>
<td>Uline.com</td>
<td>Convex Mirror - 26” Glass, Indoor</td>
<td>$69</td>
<td><a href="https://www.uline.com">https://www.uline.com</a></td>
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<tr>
<td>Circular or curved mirrors</td>
<td>Uline.com</td>
<td>Half-Dome Safety Mirror - 18”</td>
<td>$38</td>
<td><a href="https://www.uline.com">https://www.uline.com</a></td>
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<td>Circular or curved mirrors</td>
<td>Uline.com</td>
<td>Half-Dome Safety Mirror - 26”</td>
<td>$71</td>
<td><a href="https://www.uline.com">https://www.uline.com</a></td>
</tr>
<tr>
<td>Deep service counters</td>
<td>Herman Miller</td>
<td>Commend™ Nurses Station</td>
<td>$8,000</td>
<td><a href="https://www.hermanmiller.com">https://www.hermanmiller.com</a></td>
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<tr>
<td>Locks on doors</td>
<td>Bestaccess.com</td>
<td>40H SERIES</td>
<td>$246 - $831</td>
<td><a href="https://www.bestaccess.com">https://www.bestaccess.com</a></td>
</tr>
<tr>
<td>Locks on doors</td>
<td>Bestaccess.com</td>
<td>SPSL, SSRL, SPSE</td>
<td>$1,118 - $1,526</td>
<td><a href="https://www.bestaccess.com">https://www.bestaccess.com</a></td>
</tr>
<tr>
<td>Locks on doors</td>
<td>CodeLocks Americas</td>
<td>CL600 Panic Access Kit</td>
<td>$369</td>
<td><a href="https://www.codelocks.us">https://www.codelocks.us</a></td>
</tr>
<tr>
<td>Locks on doors</td>
<td>CodeLocks Americas</td>
<td>CL2255 Electronic Tubular Mortise Latch</td>
<td>$225</td>
<td><a href="https://www.codelocks.us">https://www.codelocks.us</a></td>
</tr>
<tr>
<td>Electronic access controls</td>
<td>Dormakaba</td>
<td>Keyscan LUNA SDAC Smart Kit</td>
<td>$1,171</td>
<td><a href="https://www.dormakaba.com">https://www.dormakaba.com</a></td>
</tr>
<tr>
<td>Electronic access controls</td>
<td>Dormakaba</td>
<td>Keyscan control unit, 1 to 8 readers</td>
<td>$1,300 - $5,277</td>
<td><a href="https://www.dormakaba.com">https://www.dormakaba.com</a></td>
</tr>
</tbody>
</table>
Table D-4, continued. Engineering and Work Practice Control Equipment, Product and Source

<table>
<thead>
<tr>
<th>Control Name</th>
<th>Vendor</th>
<th>Product name</th>
<th>Price per unit</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic access controls</td>
<td>Dormakaba</td>
<td>Keyscan Aurora (control management software)</td>
<td>$1,557</td>
<td><a href="https://www.dormakaba.com">https://www.dormakaba.com</a></td>
</tr>
<tr>
<td>Electronic access controls</td>
<td>Dormakaba</td>
<td>Keyscan K-SMART3 Reader Program Card (5)</td>
<td>$33</td>
<td><a href="https://www.dormakaba.com">https://www.dormakaba.com</a></td>
</tr>
<tr>
<td>Electronic access controls</td>
<td>Dormakaba</td>
<td>Keyscan Proximity Reader</td>
<td>$228</td>
<td><a href="https://www.dormakaba.com">https://www.dormakaba.com</a></td>
</tr>
<tr>
<td>Electronic access controls</td>
<td>Dormakaba</td>
<td>Keyscan Proximity Keypad Reader</td>
<td>$765</td>
<td><a href="https://www.dormakaba.com">https://www.dormakaba.com</a></td>
</tr>
<tr>
<td>Enclosed workstations with shatter-resistant glass</td>
<td>Professional Plastics</td>
<td>PLEXIGLASS Sheet - Acrylic Sheet - EXTRUDED (0.1&quot; thick, 12&quot; x 12&quot;)</td>
<td>$55</td>
<td><a href="https://www.professionalplastics.com">https://www.professionalplastics.com</a></td>
</tr>
<tr>
<td>Enclosed workstations with shatter-resistant glass</td>
<td>Professional Plastics</td>
<td>PLEXIGLASS Sheet - Acrylic Sheet - EXTRUDED (0.25&quot; thick, 48&quot; x 96&quot;)</td>
<td>$236</td>
<td><a href="https://www.professionalplastics.com">https://www.professionalplastics.com</a></td>
</tr>
<tr>
<td>Opaque glass in patient rooms</td>
<td>Smart Tint</td>
<td>Smart Tint® film 4 ft. x 6.5 ft.</td>
<td>$1,534</td>
<td><a href="https://www.smarttint.com">https://www.smarttint.com</a></td>
</tr>
<tr>
<td>Opaque glass in patient rooms</td>
<td>Home Depot</td>
<td>Gila 4 ft. x 6.5 ft. Frosted Privacy Window Film</td>
<td>$24</td>
<td><a href="https://www.homedepot.com">https://www.homedepot.com</a></td>
</tr>
<tr>
<td>Personal panic devices</td>
<td>BEC Integrated Solutions</td>
<td>Wireless Panic Button Pre-programmed Commercial Security System</td>
<td>$1,979</td>
<td><a href="https://becintegrated.com">https://becintegrated.com</a></td>
</tr>
<tr>
<td>Personal panic devices</td>
<td>BEC Integrated Solutions</td>
<td>Supervised Long Range Transmitter DXS-LRC SST00124</td>
<td>$33</td>
<td><a href="https://becintegrated.com">https://becintegrated.com</a></td>
</tr>
<tr>
<td>CCTV system</td>
<td>Surveillance-Video</td>
<td>RVS Systems RVS-AR-DVR Mobilemule 4 Channel DVR with GPS Tracking and AHD Dome Camera, Western Digital 1TB 2.5 Inch Hard Drive, 66' Camera Cable</td>
<td>$554</td>
<td><a href="https://www.surveillance-video.com">https://www.surveillance-video.com</a></td>
</tr>
<tr>
<td>CCTV system</td>
<td>Surveillance-Video</td>
<td>Vivotek ND8322P-2FE30 8 Channel NVR with No HDD with 2 X 5MP Indoor Fisheye IP Security Cameras</td>
<td>$924</td>
<td><a href="https://www.surveillance-video.com">https://www.surveillance-video.com</a></td>
</tr>
<tr>
<td>CCTV system</td>
<td>Surveillance-Video</td>
<td>Cantek PT8MPTZ2TB Powerful 8 Channel Pan/Tilt/Zoom 1080P HD Security System</td>
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<td><a href="https://www.surveillance-video.com">https://www.surveillance-video.com</a></td>
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Appendix E: Average Per-Facility Engineering Control Costs, by Control Type and NAICS (All Ownerships)

Table E-1, Table E-2, and Table E-3 present per-facility control equipment costs, by control type, on a weighted-average basis across all ownership categories for large, small, and very small facilities, respectively.
### Table E-1. Engineering Control Equipment Cost per Facility, Large Facilities, all Ownerships ($2019)

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Note: NA = no establishments; A $0 indicates zero cost for these establishments.
Table E-2. Engineering Control Equipment Cost per Facility, Small Facilities, all Ownerships ($2019)

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Note: A $0 indicates zero cost for these establishments.
Section VI. Federal Rules That May Duplicate, Overlap, or Conflict with the Draft Standard

The Regulatory Flexibility Act (RFA) requires that the agency’s initial regulatory flexibility analysis identify, “to the extent practicable, [] all relevant Federal rules which may duplicate, overlap or conflict with the proposed rule.” 5 U.S.C. § 603(b)(5). OSHA has identified several federal rules and guidelines that may generally address workplace violence against employees in the healthcare and social assistance sector. Below, the agency discusses whether these rules and guidelines would duplicate, overlap, or conflict with the draft regulatory language. While some federal rules may have overlapping requirements, OSHA did not identify any rules that were in conflict. The agency therefore believes that no federal rules would prevent compliance with the draft standard.

Other Federal Rules

The first set of federal rules or guidelines that OSHA identified are regulations promulgated by the Department of Veterans Affairs (VA). These VA regulations apply to facilities operated by the Veterans Health Administration (VHA), which is the nation’s largest health care system, employing more than 367,200 full-time health care professionals and support staff at 1,293 health care facilities, including 171 VA Medical Centers and 1,112 outpatient sites (VHA outpatient clinics). While there may be some overlap between VA regulations and OSHA’s draft standard, OSHA is not aware of any conflicts and the VA regulations would not obviate the need for OSHA’s draft standard because the latter also covers a wide range of workplaces not subject to VA regulations.

VA regulations require various types of facilities to provide a physical environment that protects the health and safety of patients, employees, and the public. See, e.g., 38 C.F.R. § 51.200 (nursing homes); 38 C.F.R. § 59.130(a) (state homes). It is OSHA’s understanding that the vast majority of facilities subject the VA regulations are not operated by employers who qualify as “small entities” for the purpose of SBREFA. The VA regulations are generalized requirements, and there are no specific requirements that duplicate, overlap, or conflict with the requirement in OSHA’s draft standard for covered employers to develop and implement workplace violence prevention programs, conduct hazard assessments, implement control measures (including engineering and work practice controls to eliminate or minimize employee exposure to hazards), implement a training program, and investigate and record workplace violence incidents.

In addition, one VA regulation requires employees to report each work-connected injury, accident, or disease they suffer. See 38 C.F.R. § 0.735–12(a)(2). Employees must also report actual or possible violations of the law related to public safety and sexual assault with the VA. See 38 C.F.R. §§ 1.201, 1.203. While this reporting requirement slightly overlaps with and duplicates the requirement in OSHA’s draft standard for covered employers to implement and maintain a violent incident reporting system, these requirements do not conflict.

44 Separately, the OSH Act does not apply to “working conditions” of workers with respect to which another federal agency has “exercise[d] statutory authority to prescribe or enforce standards or regulations affecting occupational safety or health.” 29 U.S.C. § 653(b)(1).
The Honoring America’s Veterans and Caring for Camp Lejeune Families Act of 2012 directed the VA to develop and implement a comprehensive policy on the reporting and tracking of sexual assault and other public safety incidents that occur at each VA medical facility. See 38 U.S.C. § 1709(a). VHA Directive 2012-026, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities implemented this unified policy.

The VHA Directive expired on February 28, 2015, and has not been updated. In 2015, however, the VHA implemented the Disruptive Behavior Reporting System, which allows all VHA staff to report disruptive behavioral events. See 38 C.F.R. § 17.107. While there may be some overlap or duplication between this requirement and OSHA’s draft rule, there would be no conflict because OSHA’s draft standard also requires employers to implement and maintain a violent incident reporting system and establish and implement policies and procedures for effective communication of a patient/client/resident’s history or potential for violence.

Finally, the VHA issued VHA Directive 5019.01, VHA Workplace Violence Prevention Program, on August 23, 2021, which requires the development and implementation of a VHA Workplace Violence Prevention Program (WVPP) in VA medical facility workplaces. In many ways, Directive 5019.01 does not so much establish new requirements for VHA facilities, but rather pools disparate pre-existing requirements that have been in effect for many years, to one uniform source, along with guidance, to aid with compliance with these requirements in VHA facilities. The policy for implementing the WVPP is supported by several established guidelines on workplace violence, including the requirements from the Joint Commission (discussed below) and OSHA. Similar to the draft regulatory text OSHA has provided, the VHA Directive requires employee education, data collection and analysis, behavioral threat assessment and management, and communication protocols.

The WVPP under the VHA Directive has several specific components, including the Prevention and Management of Disruptive Behavior Program as part of the mandatory training of all VHA personnel in workplace violence prevention; the Disruptive Behavior Reporting System to report disruptive or violent events; the Workplace Behavioral Risk Assessment that provides local workplace violence prevention programs with estimates of workplace violence risk exposure specific to the facility; the behavioral threat assessment to estimate the risk an individual poses; behavioral threat management based on the findings of the individualized behavioral threat assessment; and pathways for communication of the threat management recommendations.

VHA Directive 5019.01, Appendices A-F.

The Directive addresses governance of the WVPP in VA medical facility workplaces only. While some of these components are similar to the types of measures that are included in the draft regulatory text, OSHA does not believe that any of the provisions in the draft regulatory texts are in direct conflict with the VHA Directive.

There may be overlapping elements between the VHA Directive and the draft regulatory text that OSHA has provided in this package. However, as noted above, this Directive applies to employees in VA medical facilities only and not to the healthcare and social assistance industry as a whole. Further, OSHA has enforcement mechanisms that the VHA does not have, such as responding to complaints, conducting inspections, and issuing notices of unsafe and unhealthful
working conditions. The joint effect of an OSHA standard and the VHA Directive can reasonably be expected to result in better compliance than either one alone. Thus, such a rule would complement the VHA Directive and would be likely to improve overall compliance with workplace violence prevention practices in VA workplaces that would be covered by the draft standard.

The second set of federal rules or guidelines that OSHA identified as potentially duplicative, overlapping, or conflicting are regulations promulgated by the Centers for Medicare and Medicaid Services (CMS). CMS regulations have a much narrower scope than OSHA standards, as they do not cover providers that do not accept or collect payment through Medicare or Medicaid. However, they do cover health care providers that accept or collect payment through Medicare or Medicaid, including hospitals, nursing homes, home health care (of kinds covered by Medicare), and ambulatory care facilities.

CMS regulations require various types of facilities to provide a physical environment that protects the health and safety of patients, employees, and the public. See, e.g., 42 C.F.R. § 418.110(c) (hospice care facilities that provide inpatient care in their own facilities); 42 C.F.R. § 483.90 (long term care facilities); 42 C.F.R. § 485.62 (comprehensive outpatient rehabilitation facilities); 42 C.F.R. § 485.918(e)(1) (Community Mental Health Centers).

These regulations are general and do not require the implementation of any specific controls. There would be no conflict between OSHA’s draft standard and these CMS regulations because OSHA’s draft standard requires employers to use engineering, administrative, and work practice controls, as well as personal protective equipment to eliminate or minimize employee exposure to hazards. OSHA’s draft standard therefore provides specific requirements that are consistent with the more general CMS requirements. Facilities under OSHA’s jurisdiction that are complying with the CMS requirements may already be meeting certain requirements contained in the draft standard.

CMS regulations establish standards for the use of restraints or seclusion to ensure the safety of patients, employees, and others in various types of facilities. See, e.g., 42 C.F.R. § 482.13(e) (hospitals); 42 C.F.R. § 483.450(d) (intermediate care facilities for individuals with intellectual disabilities); 42 C.F.R. §§ 483.350–376 (psychiatric residential treatment facilities for individuals under age 21). While OSHA’s draft standard references the use of restraints, it does not overlap, duplicate, or conflict with these CMS regulations because OSHA’s draft standard simply requires employers who use restraint methods to have standard operating procedures for the appropriate use of restraints by employees, in accordance with federal, state, and local laws. The CMS requirements provide specific standards for the appropriate use of restraints that may be incorporated into the policies and procedures required in OSHA’s draft standard and are therefore consistent with OSHA’s draft standard. Facilities under OSHA’s jurisdiction that are complying with the CMS requirements may already be meeting certain requirements contained in the draft standard.

CMS regulations for psychiatric residential treatment facilities for individuals under age 21 require staff to document injuries to staff resulting from an emergency safety intervention (such as restraints or seclusion), and to meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries. 42 C.F.R. § 483.372(c)–(d).
These regulations also require staff in these facilities to have ongoing education, training, and demonstrated knowledge of: (1) techniques to identify behaviors, events, and factors that may trigger emergency safety situations; (2) nonphysical intervention skills like de-escalation techniques; and (3) safe use of restrain and seclusion. 42 C.F.R. § 483.376(a)(1)—(3).

OSHA’s draft standard requires employers to implement and maintain a violent incident reporting system and to conduct hazard assessments and is therefore consistent with the CMS requirements. Likewise, OSHA’s draft standard would also require training on, among other things, how to recognize threatening behaviors and de-escalation techniques. While there may be slight overlap with the CMS regulations related to employee injuries in these facilities, the requirements do not conflict. Facilities under OSHA’s jurisdiction that are complying with the CMS requirement may already be meeting certain requirements contained in the draft standard.

One CMS regulation requires intermediate care facilities for individuals with intellectual disabilities to provide a staff-to-client ratio of at least 1 to 3.2 for clients who are aggressive, assaulitive, or security risks. See 42 C.F.R. § 483.430(d)(3)(i). There would be no conflict between OSHA’s draft standard and this CMS regulation because OSHA’s draft standard does not require a specific staff-to-patient ratio; rather, it requires employers to assign or place sufficient numbers of staff to reduce workplace violence hazards. The CMS requirement provides a specific staffing standard for a particular type of facility and is a ratio related to patient care, not staff safety. There is no conflict between this requirement and OSHA’s draft standard, and some facilities under OSHA’s jurisdiction that are already complying with the CMS requirement may be meeting certain requirements contained in the draft standard.

Hospitals and long-term care facilities are required by CMS to develop and maintain an emergency preparedness plan that is based on both a facility-based and community-based risk assessment, using an all-hazards approach. See 42 C.F.R. §§ 482.15(a) (hospitals), 483.73(a) (long-term care facilities). These facilities must develop and maintain an emergency preparedness training and testing program based on the plan, risk assessment, and policies and procedures. See 42 C.F.R. §§ 482.15(d) (hospitals), 483.73(d) (long-term care facilities). This plan and the corresponding training, like OSHA’s draft proposed hazard assessment and training requirements, are performance-oriented and do not conflict with each other. Given the performance-oriented nature of these requirements, OSHA anticipates that employers that have to comply with these CMS requirements could develop a single plan that complies with both sets of requirements.

All Medicare and Medicaid providers and suppliers are required by CMS to develop and maintain a comprehensive emergency preparedness plan that is based on both a facility-based and community-based risk assessment, using an all-hazards approach. See 42 C.F.R. §§ 482.15(a) (hospitals), 483.73(a) (long-term care facilities). The purpose of this rule is to establish federally enforceable consistent requirements for these providers to have a plan to protect patients, staff and communities during local, state, and national natural or man-made disasters or emergencies. The required four core elements of an emergency preparedness plan are: (1) risk assessment and emergency planning (2) policies and procedures (3) communication plan, and (4) training and testing. See 42 C.F.R. § 494.62. The emergency preparedness rule stipulates that an all-hazards approach be used for the risk assessment, training, testing, policies, procedures, and communication plan See 42 C.F.R. § 494.62, § 482.15(d), 483.73(d).

There may be overlapping elements between the CMS emergency preparedness rule and the
proposed OSHA standard. The CMS rule is a non-prescriptive approach for preparing Medicare and Medicare providers and suppliers for natural and man-made emergencies. The CMS mandated facility specific assessment of emergencies may encompass man-made emergencies, including workplace violence. However, the CMS rule does not include language specific to workplace violence assessment, program implementation, and enforcement. There is a potential for overlap in the hazard assessment and training requirements in the proposed and existing rule. However, the CMS required plan and the corresponding training, like OSHA’s draft proposed hazard assessment and training requirements, are performance-oriented and do not conflict with each other.

As described the proposed rule provides an enforceable standard specific to the hazard of workplace violence. In addition, the proposed OSHA standard covers facilities outside CMS jurisdiction. It is anticipated the proposed OSHA standard would enhance the successful implementation of workplace violence prevention measures identified in the CMS rule. Given the performance-oriented nature of these requirements, OSHA anticipates that employers that have to comply with these CMS requirements could develop a single plan for both sets of requirements.

OSHA has also included multiple provisions regarding assessment of workplace violence hazards specifically for home healthcare settings, particularly in Table E-1, in this draft rule. CMS also includes assessments that may identify violent behaviors in home healthcare. Specifically, the requirement for such assessments exist at 42 CFR § 484.55 Condition of participation: Comprehensive assessment of patients, which requires an Outcome and Assessment Information Set (OASIS) assessment.

The OASIS is a patient-specific, standardized assessment tool used in Medicare home health care to plan care, determine reimbursement, and measure quality of care associated with the requirements under 42 C.F.R. § 484. The purpose of the OASIS is to provide a standardized assessment tool to monitor quality of care. OASIS evaluations are conducted at the start of care, as well as in 60-day intervals or other intervals, as applicable (e.g., discharge, transfer, and change in condition, etc.), in order to monitor patient care. Assessments are typically conducted by care providers who submit scored evaluations to case managers responsible for developing a care plan to ensure continuity of care for patients served.

Various health indicator criteria are included in the evaluation, and are recorded on the Home Health Patient Tracking Sheet (Form OMB #0938-1279). Element (M1740) of the Home Health Patient Tracking Sheet is intended to document any notable observation with regard to cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (reported or observed). These symptoms may include use of threats, physical aggression, throwing objects, punching, dangerous maneuvers with wheelchair or other objects, etc., as indicated on Form OMB #0938-1279.

Although the CMS requirements under 42 CFR § 484 – Home health services may in certain circumstances involve the assessment of patients in home healthcare settings for their propensity for violent behaviors, OSHA does not find the language in this draft regulatory text to be wholly duplicative. First, the intent of these two assessments are different. The CMS assessment under §
484.55 is primarily focused on patient healthcare needs and the limited portion relevant to potential violent behavior is intended to serve as an indicator of change in patient status or shift in patient acuity (e.g., functional impairment level is low, medium, or high), largely for the purpose of patient safety and monitoring quality of care. Conversely, the draft regulatory language OSHA has included in this package is intended to be focused on worker safety, and the assessment ties directly to specific hazard controls and other elements of a comprehensive workplace violence prevention program (WVPP).

Second, the requirements under 42 C.F.R. § 484 are intended to specifically document behaviors of the patient as may pertain to propensities for violent behavior. It is the intent of OSHA’s draft regulatory language to more broadly apply to other aspects of the home health environment as well, including the geographical area/neighborhood of the site of care, patient family members, or other members of a household or other site of care. For these reasons, OSHA has concluded that the draft regulatory text included in this package does not wholly duplicate the requirements under 42 C.F.R. § 484.55. To the extent that there is any duplication between the information reported in the OASIS assessment or other information obtained as part of the CMS-required assessment, OSHA’s draft standard could conceivably permit the employer to include a copy of the relevant portion of the CMS assessment and reference it as part of the OSHA assessment.

None of CMS’s other regulations conflict with OSHA’s draft standard; rather, to the extent that any requirements are similar, OSHA anticipates that an OSHA standard would reinforce and strengthen compliance at all healthcare and social assistance facilities covered by the draft standard. Moreover, OSHA has enforcement mechanisms that CMS does not have (e.g., responding to complaints, conducting random unannounced inspections, and issuing citations and proposed penalties). CMS regulations, on the other hand, establish the terms of a contractual or quasi-contractual agreement between CMS and a provider. The repercussions for violating a contractual agreement “stand[] in sharp contrast to the civil and criminal penalties provided for in the [OSH] Act.” Cf. Ensign-Bickford Co. v. OSHRC, 717 F.2d 1419, 1421 n.3 (D.C. Cir. 1983) (holding an agency regulates working conditions within the meaning of section 4(b)(1) of the OSH Act only if it “implements [a] regulatory apparatus necessary to replace those safeguards required by the Act.”).

The Joint Commission

The Joint Commission is an independent non-profit organization that accredits and certifies more than 22,000 healthcare organizations and programs in the United States, including hospitals and healthcare organizations that provide ambulatory and office-based surgery, behavioral health, home healthcare, and laboratory and nursing care center services. Through this accreditation, providers are afforded the right to participate in CMS funding streams. The Joint Commission’s primary role is to certify healthcare facilities as meeting the necessary criteria for the best patient care. As a private, non-profit organization, it does not mandate participation from any healthcare facility.

The Joint Commission recently published new requirements for the prevention of workplace violence in all Joint Commission-accredited hospitals in the Environment of Care (EC.02.01.01, EC.04.01.01), Human Resources (HR.01.05.03), and Leadership (LD.03.01.01) chapters. These requirements will be effective January 1, 2022. The new Joint Commission requirements for the
prevention of workplace violence include an annual worksite analysis, assessment of risks, reporting processes, development of policies and procedures to prevent workplace violence, and education and training interventions such as de-escalation (R³ Report - Requirement, Rationale, Reference, 2021). OSHA does not believe that any action by the agency to promulgate a standard on workplace violence in healthcare and social assistance would conflict with the current accreditation standards of the Joint Commission.

Some overlapping elements may exist between the Joint Commission requirements and the regulatory text that OSHA has provided in this package. However, compliance with the Joint Commission requirements is generally validated through periodic accreditation surveys of the employer’s facility by the Joint Commission. The Joint Commission requirements establish the terms of a contractual or quasi-contractual agreement between the Joint Commission, CMS, and a provider. As noted above, OSHA has enforcement mechanisms that the Joint Commission and CMS do not have. For example, OSHA can respond to complaints, conduct random unannounced inspections, and issue citations and proposed penalties. Furthermore, the Joint Commission accredits approximately 22,000 establishments, whereas the regulatory text that OSHA has provided would apply to upwards of 300,000 healthcare and social assistance-providing establishments.

Additionally, the joint effect of an OSHA standard and the Joint Commission requirements can reasonably be expected to result in better protection for workers at covered facilities than compliance with the Joint Commission requirements alone. This conclusion is borne out by the joint effect of CMS’s enforcement of its infection control regulations alongside OSHA’s enforcement of its existing Bloodborne Pathogens standard – a regime that has been in place for thirty years. The Bloodborne Pathogens standard, which has existed alongside the CMS regulations since its promulgation, led to significant declines in bloodborne diseases among healthcare workers. See 29 C.F.R. 1910.1030. Thus, such a rule would complement the Joint Commission requirements and would likely improve overall compliance with workplace violence prevention practices.

**OSHA Standards**

OSHA does not have any standards that already cover workplace violence against employees in the healthcare and social assistance sector.

**References**

CMS (2022) Home Health Patient Tracking Sheet (Form OMB #0938-1279)  


Section VII. Regulatory Alternatives and Options

This section describes the regulatory alternatives and options OSHA is considering. Table 1 summarizes the annualized costs for the potential standard, as calculated in Section V, using a three percent discount rate. Some of the regulatory alternatives and options discussed below would alter the scope, and thus the number of affected employers and employees, while others would expand, modify, or eliminate specific requirements that OSHA is considering.

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

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

Notable from Table 1 is the fact that the largest portion of total costs is the element of workplace violence prevention training. Of the estimated cost total of $1.22 billion, training accounts for $909 million, or approximately 75 percent of total costs.

Education and training are key elements of a workplace violence protection program, and help ensure that all staff members are aware of potential hazards and how to protect themselves and their coworkers through established policies and procedures. Such training can be part of a broader type of instruction that includes protecting patients and clients (such as training on de-escalation techniques). This training can: (1) help raise the overall safety and health knowledge across the workforce, (2) provide employees with the tools needed to identify workplace safety and security hazards, and (3) address potential problems before they arise and ultimately reduce the likelihood of workers being assaulted.

In this section, OSHA presents a number of regulatory alternatives and options. OSHA welcomes suggestions from the SERs regarding these regulatory alternatives and options, as well

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45 “Alternatives,” as referenced under section 603(c) of the Regulatory Flexibility Act (RFA), “accomplish the stated objectives of applicable statutes that minimize any significant economic impact of the proposed rule on small entities.” For the purposes of this PIRFA, the term “option” is used to describe a potential scope change or substitute measure that does not meet the RFA definition for “alternative.”

The designation of “alternative” or “option” is preliminary. OSHA will update the preliminary designation of whether a textual change to the regulatory framework is an alternative or option following the SBAR Panel Meetings involving SER participation.
as additional alternatives or options the agency should consider. The total costs of the potential regulatory alternatives and options addressing the provisions, where quantified, are summarized in Table 2 and discussed in the text, with annualized costs calculated using a three percent discount rate.
Table 2. Annualized Costs for Regulatory Alternatives, Options, and Sensitivity Tests ($2019)

<table>
<thead>
<tr>
<th>Regulatory Alternative, Option, or Sensitivity Test</th>
<th>Change in Annualized Cost ($) (3%)</th>
<th>Percent Change in Annualized Cost</th>
<th>Annualized Cost, Alternative (3%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scope</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Standard applies to “patient care” only – not “patient contact”; Exempt patient contact employees from the scope of the rule. (Scope Alternative #1)</td>
<td>($23,516,110)</td>
<td>-1.93%</td>
<td>$1,192,336,875</td>
</tr>
<tr>
<td>2. Within Social Assistance sectors, limit the scope to include only NAICS 6241, Individual and Family Services. (Scope Alternative #2)</td>
<td>($23,997,530)</td>
<td>-2.0%</td>
<td>$1,191,855,456</td>
</tr>
<tr>
<td>3. Eliminate non-fixed location sectors from the standard (Emergency Response, Home Healthcare, and Field-Based Social Assistance Services) (Scope Alternative #3)</td>
<td>($285,391,219)</td>
<td>-23.5%</td>
<td>$930,461,766</td>
</tr>
<tr>
<td>4. Expand scope to include locations where healthcare services are provided in correctional facilities and educational settings. (Scope Option #1)</td>
<td>$30,155,251</td>
<td>2.48%</td>
<td>$1,246,008,236</td>
</tr>
<tr>
<td><strong>C. WVPP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Staggered periodicity of annual review (biennially or triennially (cost change shown for biennial estimate) vs. annually) (WVPP Alternative #1)</td>
<td>($22,037,560)</td>
<td>-1.8%</td>
<td>$1,193,815,425</td>
</tr>
<tr>
<td><strong>D. Hazard Assessment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Change workplace violence incident records review for annual hazard assessments from three years of data to just one year or two years of incident data. (Hazard Assessment Alternative #1)</td>
<td>($5,663,316)</td>
<td>-0.5%</td>
<td>$1,210,189,669</td>
</tr>
<tr>
<td>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)</td>
<td>($49,264,063)</td>
<td>-4.1%</td>
<td>$1,166,588,922</td>
</tr>
<tr>
<td>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)</td>
<td>($157,322,225)</td>
<td>-12.9%</td>
<td>$1,058,530,760</td>
</tr>
<tr>
<td><strong>E. Hazard Controls</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Require only hazard assessment, development of a plan, and provision of training (Hazard Controls Alternative #1)</td>
<td>($101,667,773)</td>
<td>-8.4%</td>
<td>$1,114,185,212</td>
</tr>
<tr>
<td>10. Require that employers implement administrative/work-practice controls only -- No requirement for employers to implement environmental or engineering controls (Hazard Controls Alternative #1a)</td>
<td>($93,996,083)</td>
<td>-7.7%</td>
<td>$1,121,856,902</td>
</tr>
<tr>
<td>11. Require that employers implement a limited set of environmental or engineering controls (Hazard Control Alternative #1b)</td>
<td>Not quantified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Remove requirement for all employers to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #2)</td>
<td>($9,965,590)</td>
<td>-0.8%</td>
<td>$1,205,887,395</td>
</tr>
<tr>
<td>Regulatory Alternative, Option, or Sensitivity Test</td>
<td>Change in Annualized Cost ($) (3%)</td>
<td>Percent Change in Annualized Cost</td>
<td>Annualized Cost, Alternative (3%)</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>13. Remove requirement for small entities to develop a standard operating procedure for mass shooter/mass casualty situations (Hazard Controls Alternative #3)</td>
<td>($1,047,187)</td>
<td>-0.1%</td>
<td>$1,214,805,798</td>
</tr>
<tr>
<td><strong>F. Training</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Remove annual training; retain initial training (Training Alternative #1)</td>
<td>($755,090,859)</td>
<td>-62.1%</td>
<td>$460,762,126</td>
</tr>
<tr>
<td>15. Require annual training for a more limited subset of employees (e.g., those with direct-patient/client/resident care and violent incident response duties only) (Training Alternative #2)</td>
<td>($19,650,597)</td>
<td>-1.6%</td>
<td>$1,196,202,388</td>
</tr>
<tr>
<td>16. Reduce the expected number of training hours (Training Alternative #3)</td>
<td>($454,405,330)</td>
<td>-37.4%</td>
<td>$761,447,655</td>
</tr>
<tr>
<td>17. Require refresher training every 3 years instead of annually (Training Alternative #3)</td>
<td>($510,796,039)</td>
<td>-42.0%</td>
<td>$705,056,946</td>
</tr>
<tr>
<td>17a. Require refresher training every 2 years instead of annually (Training Alternative #3a)</td>
<td>($419,738,961)</td>
<td>-34.5%</td>
<td>$796,114,024</td>
</tr>
<tr>
<td>18. Require 24 hours of training for small facilities (≤2 employees on site) (Training Option #1)</td>
<td>$14,139,424</td>
<td>1.2%</td>
<td>$1,229,992,409</td>
</tr>
<tr>
<td>19. Reduction of expectation of training length for the most advanced level of employee workplace violence prevention training (Training Sensitivity Test #1)</td>
<td>($19,848,474)</td>
<td>-1.6%</td>
<td>$1,196,004,511</td>
</tr>
<tr>
<td><strong>G. Violent Incident Investigation &amp; Recordkeeping</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Require post-incident investigations only for workplace violence incidents involving physical assault (Incident Investigation Alternative #1)</td>
<td>($13,729,830)</td>
<td>-1.1%</td>
<td>$1,202,123,156</td>
</tr>
<tr>
<td>21. Require post-incident medical and psychological evaluations and treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) For WPV Recordable, Lost-Work Incidents (Post-incident Evaluations Options #1)</td>
<td>$108,746,045</td>
<td>8.9%</td>
<td>$1,324,599,030</td>
</tr>
<tr>
<td>(b) For WPV Recordable, Non-Lost-Work Incidents (Post-incident Evaluations Options #2)</td>
<td>$231,641,450</td>
<td>19.1%</td>
<td>$1,447,494,435</td>
</tr>
<tr>
<td>(c) For Total Recordable WPV Incidents (Post-incident Evaluations Options #3)</td>
<td>$340,387,495</td>
<td>28.0%</td>
<td>$1,556,240,480</td>
</tr>
<tr>
<td>22. Effective Date of the Standard Alternative #1: Extension of compliance date for requirements in paragraphs (e) Control Measures and (f) Training or any other provisions in this draft standard might require more than six months to come into compliance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. General Alternative: OSHA opts to take no action on this draft standard on Prevention of Workplace Violence in Healthcare and Social Assistance, and continues to address workplace violence hazards in healthcare and social assistance solely through use of the General Duty Clause.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Alternatives and Options

This section includes alternatives that OSHA preliminarily believes may meet the agency’s statutory objectives, be feasible, and reduce the burden on small entities. Consistent with the requirements of section 603(c) of the Regulatory Flexibility Act (RFA), OSHA seeks to solicit feedback through the SBREFA process that will assist the agency in the decision-making process and help the agency clarify which of these alternatives meet the OSH Act’s requirements.

**Paragraph (b) Scope:**

*Scope Alternative #1: Standard applies to “patient care” only – not “patient contact”;
Exempt patient contact employees from the scope of the rule*

Throughout OSHA’s current draft of this regulatory text, OSHA addresses employees that are defined as those with “direct patient/client/resident contact” and those who provide “direct patient/client/resident care”.

- **Direct patient/client/resident contact employees are defined as those that perform support work that requires them to be in patient care areas.** Such work includes environmental services, engineering services, laundry services, meal delivery, information technology, and others. For purposes of SBREFA, OSHA also considers security staff to belong in this category.

- **Direct patient/client/resident care employees are defined as those having job duties that involve the delivery of healthcare services or social assistance services with hands-on or face-to-face contact with patients/clients/residents.** Employees who provide direct patient/client/resident care include nurses, physicians, nursing assistants, patient care assistants, technicians, and other healthcare workers, social workers visiting client homes, as well as employees providing emergency medical services.

Taken together, the total cost for coverage of both of these sets of employees totals $1.22 billion.

In general, workers performing duties in the direct patient/client/resident care category experience higher incidents of workplace violence than those in the contact category. Job category can impact risk of WPV because it determines the frequency and type of contact an employee will have with patients. Employees in positions providing patient care are likely at higher risk of WPV because they spend more time interacting closely with patients and often perform more intimate care tasks. While some patient/client/resident contact duties involve significant time interacting with patients or clients and therefore carry risk of workplace violence, on average they experience fewer workplace violence incidents than those providing more intensive care, likely because the patient/client/resident contact duties typically involve less time interacting in close proximity with patients and clients than patient/client/resident care duties. Within the category of care providers, research shows that
healthcare employees in positions providing the most frequent and prolonged patient care, such as nurses, nursing aides, and home care aides, experience WPV at higher rates than those in positions requiring less frequent or prolonged patient care and/or contact, such as physicians. For example, in a survey of WPV in VHA medical centers from 1990-1991, the rate of injury due to assaultive behavior per 1,000 employees was 71.8 for nursing assistants, 34.6 for licensed practical nurses (LPNs), 22.5 for registered nurses (RNs), and 4.5 for physicians (Lehmann, et al. 1999).

Taking this into consideration, one alternative for which OSHA seeks input from SERs is on narrowing the scope of the standard to apply only for employees who categorized as direct patient/client/resident care providers (e.g., nurses, physicians, nursing assistants, patient care assistants, technicians, and other healthcare workers, social workers visiting client homes, as well as employees providing emergency medical services).

This alternative would only cover employees responsible for direct patient/client/resident care, that involve hands-on or face-to-face interaction with patients or clients. Employees who provide support work (i.e., housekeeping, maintenance, meal delivery, engineering, laundry services, etc.) would not be covered. If OSHA were to cover only these direct patient/client/resident care, this would result in a cost reduction of $23.5 million, a 1.9 percent reduction in costs in relation to the default (baseline) cost total of $1.22 billion for the entire standard. Security employees, who for the purposes of SBREFA are designated as patient contact employees, would not be covered under this proposed alternative. For the 201,698 employers affected by this regulatory alternative, the cost reduction would be approximately $116.59 per employer.

OSHA views this alternative with some degree of disfavor because the agency believes that all employees that are exposed to any measure of Type-II workplace violence need to be protected from the hazard. Additionally, studies show that certain kinds of workers, such as security personnel, who engage in patient/client/resident contact still face high rates of workplace violence (Lehmann, et al. 1999). Furthermore, assuming that patient/resident/contact employees may account for approximately 20 percent of all WPV injuries (as discussed on page 52, in this case, that would amount to over 3,000 injuries per year severe enough to cause days away from work that would be left unaddressed. However, OSHA welcomes feedback on this regulatory alternative. OSHA also seeks input on whether the agency should include both direct patient/client/resident care AND direct patient/client/resident contact employees in the scope of this potential standard for some or all provisions. OSHA also welcomes comment on other potential alternatives for excluding some of the employees currently covered by the draft standard and whether there would be alternative protections for the employees not covered by the draft standard.

**Scope Alternative #2:** Within Social Assistance sectors, limit the scope to include only NAICS 6241, Individual and Family Services.
Social assistance is a tremendously diverse industry sector covering a broad scope of services including Individual and Family Services (NAICS 6241); Community Food and Housing, and Emergency and Other Relief Services (NAICS 6242); and Vocational Rehabilitation Services (NAICS 6243). The descriptions of NAICS 6241, 6242, and 6243 in this section are from United States Census Bureau, North American Industry Classification System, 2022 NAICS, https://www.census.gov/naics/ (accessed February 4, 2022).

- NAICS 6241 – Individual and Family Services – “This Industry group comprises establishments primarily engaged in providing nonresidential social assistance to children and youth, the elderly, persons with disabilities, and all other individuals and families.”

- NAICS 6242 – Community Food and Housing, and Emergency and Other Relief Services – “This industry group comprises establishments primarily engaged in one of the following: (1) collecting, preparing, and delivering food for the needy; (2) providing short-term emergency shelter, temporary residential shelter, transitional housing, volunteer construction or repair of low-cost housing, and/or repair of homes for individuals or families in need; or (3) providing food, shelter, clothing, medical relief, resettlement, and counseling to victims of domestic or international disasters or conflicts (e.g., wars).”

- NAICS 6243 – Vocational Rehabilitation Services – “This industry comprises (1) establishments primarily engaged in providing vocational rehabilitation or habilitation services, such as job counseling, job training, and work experience, to unemployed and underemployed persons, persons with disabilities, and persons who have a job market disadvantage because of lack of education, job skill, or experience and (2) establishments primarily engaged in providing training and employment to persons with disabilities. Vocational rehabilitation job training facilities (except schools) and sheltered workshops (i.e., work experience centers) are included in this industry.”

BLS data indicate elevated rates of workplace violence across these social assistance sectors compared with the average for general industry. For example, whereas the average rate for workplace violence injuries for all industries in 2019 was 2.0 per 10,000 FTEs, the incidence rates for NAICS 6241 - Individual and Family Services, NAICS 6242 - Emergency and Other Relief Services, and NAICS 6243 - Vocational Rehabilitation Services were, respectively, 12.4, 8.9, and 21.8. (BLS Table R-8, 2019)

OSHA recognizes that the sector of social assistance most closely aligned with that of the healthcare industry, in terms clientele, job duties, exposure frequency, and overlap with

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46 Also within the Social Assistance sector (NAICS 624) is NAICS 6244 – Child Day Care Services. OSHA has made a preliminary determination to exclude child day care services from the scope of the regulatory framework, as indicated within the scope of the draft regulatory text.
healthcare services, may be that of NAICS 6241 - Individual and Family Services, which includes adult day care centers (elderly, disabled, etc.), non-medical home care of the elderly, disability support groups, companion services for elderly or disabled clients, and senior citizen centers. NAICS 6241 also encompasses alcoholism and drug addiction counseling, self-help organizations, hotline centers, counseling services, crisis centers (for rape, suicide, etc.), support group services and other individual and family social services. Finally, NAICS 6241 also includes adoption agencies, youth centers (except recreational only), foster care placement services/agencies, and child welfare services.

OSHA seeks feedback on the applicability of the draft standard to NAICS 6242 and 6243. These sectors are similar to healthcare providers in terms of prolonged close exposure between clients and providers, but OSHA recognizes that employers in this industry may follow operational models and handle social issues that may be significantly dissimilar to the operational models and issues in traditional healthcare settings. OSHA is interested to hear from SERs about how effectively the draft regulatory text (which is directed largely toward the healthcare sector) could be effectively applied in settings that are more directed to community food services, temporary shelters, other community housing services, job counseling, job training, work experience, and similar services.

OSHA is concerned about this alternative, however, because the rates of violence are either similar or even higher in 6242 and 6243 than in 6241, and these workers also need protection from workplace violence. As such, in this case, that would amount to over 670 injuries per year severe enough to cause days away from work that would be left unaddressed. Nonetheless, OSHA also welcomes feedback from SERs on whether the totality of establishments that operate under NAICS 624 should be covered in the scope of this draft standard. OSHA also understands that social assistance services do not always fit into such distinct categories, and that there may be considerable overlap between the NAICS sectors described above, and the services that are offered to social assistance clients through social assistance establishments.

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

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

OSHA’s proposed scope in this draft regulatory text covers a diverse range of sectors of the healthcare and social assistance industry:

(i) Hospitals, including emergency departments;
(ii) Psychiatric hospitals and residential behavioral health facilities;
(iii) Ambulatory mental healthcare and ambulatory substance abuse treatment centers;
(iv) Freestanding emergency centers;
(v) Residential care facilities;
(vi) Home healthcare;
(vii) Emergency medical services; and
(viii) Social assistance (excluding child day care centers).

Exhibit 1, below, presents, by four-digit NAICS categories within private industry, the 2019 lost-workday incidence rates for two injury events of concern to OSHA: (1) intentional injury by other person and (2) unintentional injury from physical contact while restraining.

### Exhibit 1. Lost Work-Day Incident Rates (incidents per 10,000 FTEs)- Private industry

<table>
<thead>
<tr>
<th>NAICS</th>
<th>NAICS Description</th>
<th>Intentional Injury by Other Person</th>
<th>Injured by physical contact while restraining--unintentional</th>
<th>Total WPV Lost-Work Day Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>621112</td>
<td>Offices of Physicians, Mental Health Specialists</td>
<td>26.6</td>
<td>0.0</td>
<td>26.6</td>
</tr>
<tr>
<td>621300</td>
<td>Offices of other health practitioners</td>
<td>10.5</td>
<td>2.6</td>
<td>13.1</td>
</tr>
<tr>
<td>621420</td>
<td>Outpatient Mental Health and Substance Abuse</td>
<td>3.9</td>
<td>0.4</td>
<td>4.3</td>
</tr>
<tr>
<td>621493</td>
<td>Freestanding Ambulatory Surgical, Emergency</td>
<td>3.9</td>
<td>0.4</td>
<td>4.3</td>
</tr>
<tr>
<td>621610</td>
<td>Home Health Care Services</td>
<td>4.1</td>
<td>-</td>
<td>4.1</td>
</tr>
<tr>
<td>621910</td>
<td>Ambulance Services</td>
<td>3.4</td>
<td>2.2</td>
<td>5.6</td>
</tr>
<tr>
<td>622110</td>
<td>General Medical and Surgical Hospitals</td>
<td>9.7</td>
<td>2.4</td>
<td>12.1</td>
</tr>
<tr>
<td>622210</td>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>124.9</td>
<td>42.8</td>
<td>167.7</td>
</tr>
<tr>
<td>622310</td>
<td>Specialty Hospitals (excl. Psychiatric, Substance)</td>
<td>12.8</td>
<td>3.9</td>
<td>16.7</td>
</tr>
<tr>
<td>623111</td>
<td>Nursing Care Facilities (Skilled Nursing Facilities)</td>
<td>14.9</td>
<td>0.3</td>
<td>15.2</td>
</tr>
<tr>
<td>623210</td>
<td>Residential Intellectual, Developmental Disability</td>
<td>41.7</td>
<td>11.5</td>
<td>53.2</td>
</tr>
<tr>
<td>623220</td>
<td>Residential Mental Health and Substance Abuse</td>
<td>41.7</td>
<td>11.5</td>
<td>53.2</td>
</tr>
<tr>
<td>623311</td>
<td>Continuing Care Retirement Communities</td>
<td>8.5</td>
<td>0.7</td>
<td>9.2</td>
</tr>
<tr>
<td>623312</td>
<td>Assisted Living Facilities for the Elderly</td>
<td>8.5</td>
<td>0.7</td>
<td>9.2</td>
</tr>
<tr>
<td>623990</td>
<td>Other Residential Care Facilities</td>
<td>61</td>
<td>29</td>
<td>90.0</td>
</tr>
<tr>
<td>624110</td>
<td>Child and Youth Services</td>
<td>29.2</td>
<td>6.9</td>
<td>36.1</td>
</tr>
<tr>
<td>624120</td>
<td>Services for Elderly and Persons with Disabilities</td>
<td>14.7</td>
<td>0.5</td>
<td>15.2</td>
</tr>
<tr>
<td>624190</td>
<td>Other Individual and Family Services</td>
<td>14.7</td>
<td>0.5</td>
<td>15.2</td>
</tr>
<tr>
<td>624210</td>
<td>Community Food Services</td>
<td>7.5</td>
<td>-</td>
<td>7.5</td>
</tr>
<tr>
<td>624221</td>
<td>Temporary Shelters</td>
<td>17.5</td>
<td>-</td>
<td>11.80</td>
</tr>
<tr>
<td>624229</td>
<td>Other Community Housing Services</td>
<td>17.5</td>
<td>-</td>
<td>11.80</td>
</tr>
<tr>
<td>624230</td>
<td>Emergency and Other Relief Services</td>
<td>17.5</td>
<td>-</td>
<td>7.50</td>
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<td>Vocational Rehabilitation Services</td>
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<td>-</td>
<td>18.70</td>
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<tr>
<td></td>
<td>Firefighter-EMTs</td>
<td>2</td>
<td>1.3</td>
<td>3.3</td>
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</tbody>
</table>

Source: OSHA, 2022, based on BLS (2021)
Note: A “-” means the statistic does not meet BLS standards for publication (see [https://www.bls.gov/opub/hom/soii/presentation.htm](https://www.bls.gov/opub/hom/soii/presentation.htm), Publication guidelines for SOII estimates. OSHA assigned these case rates a value of zero.)
The total cost for including all of these sectors is $1.2 billion. Many of these industry sectors typically operate within a facility or establishment-based institutional setting; however, some employees in these sectors, including Emergency Medical Services, Home Healthcare, and Field-Based Social Assistance Services, tend to work outside of a fixed location within environmental settings that may be more difficult to control. Although OSHA is concerned about not covering workers in sectors that face an elevated risk of workplace violence, it recognizes that it may be harder for these employers to comply with the proposed standard. These employees experience on the order of 2,900 WPV-related injuries per year severe enough to cause days away from work.

OSHA requests feedback on an alternative that would remove these field-based sectors -- Emergency Medical Services, Home Healthcare, and Field-Based Social Assistance Services -- from the scope of the draft regulatory text, and instead focus the potential regulation on the establishment-based operations (i.e., service center, hospital) where employers have more direct control of the work environment. Removing these three sectors from the scope would result in a cost reduction of $285.4 million and a percent change of annualized cost of -23.5 percent.

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

Under this option, locations with embedded healthcare services in both educational and correctional settings, which are not currently covered by the draft standard, would be included in the scope of the standard. OSHA is interested to receive feedback and/or receive any supporting data from SERs with experience in the provision of medical services within educational support services and correctional medical services on whether OSHA should consider adding these settings to the scope of this draft standard.

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

OSHA lacks current, complete BLS SOII statistics on the severity and incidence of workplace violence in correctional health service settings, specifically, because publicly administered correctional services (NAICS 922140), are not included within the scope of the BLS Survey of Occupational Injuries and Illnesses (SOII). However, the last time such data were available

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47 Privately operated correctional facilities are classified within NAICS 561210 – Facilities Support Services, a NAICS category that also includes other governmental service facilities. Thus, although BLS SOII statistics are reported for NAICS 5612, isolating the correct WPV incidence rates specifically for correctional facilities is beyond the scope of this PIRFA. Additionally, OSHA believes that some correctional medical service providers, many of whom may be contracted to provide health services within correctional facilities, report under the NAICS Code...
from BLS was for 2014, at which time the incidence rate in correctional institutions generally for injuries associated with intentional injury by another person was 37.2 per 10,000 full-time employees per year. (BLS Table S8, April 2016; Ex. 0063)

OSHA has collected investigative information on workplace violence in correctional health settings. For example, in 2014, OSHA inspected one site of a large multi-state for-profit correctional health service provider in New York. In response to its 2014 inspection, OSHA issued a general duty clause citation with regard to multiple correctional health workers who experienced incidents of workplace violence during the previous year, including being threatened, punched in the face resulting in loss of consciousness, locked in a cell, splashed with unknown liquid substances, and other physical assaults. (OSHA, 2014)

The literature also indicates that correctional settings generally have a high incidence rate of workplace violence. Konda et. al. set out to gain a more complete picture of work-related injuries (in general) among correctional officers. The authors identified 113 work-related fatalities and approximately 125,200 emergency department-treated non-fatal work injuries between the years of 1999 and 2008. OSHA believes these high rates of workplace violence in correctional institutions overall indicate that workers providing health care in correctional institutions also face high rates of workplace violence since they are exposed to many of the same conditions and individuals. Fatality and injury data were collected from the BLS Census of Fatal Occupational Injuries (CFOI) and the HHS National Electronic Injury Surveillance System (NEISS-Work) and compared with data from the U.S. Census Bureau and BLS Current Population Survey (CPS). According to their analyses, the authors found that non-fatal injuries among correctional officers occurred at a rate of 300.0 per 10,000 FTEs, and that the majority of these injuries were attributed to assaults and violent acts. They also found that fatality rate was 0.27 per 10,000 FTEs (an average of 11 per year) and that assaults, violent acts, and transportation-related fatalities accounted for 80 percent of all fatalities. (Konda, 2013)

OSHA also preliminarily believes that workplace violence that affects healthcare professionals serving various educational institutions (e.g., elementary and secondary schools, junior colleges, colleges, universities, and professional schools, technical and trade schools, and other school and instruction settings) may be worth additional consideration.

OSHA lacks specific data on the extent of the incidence of workplace violence in school health service settings, however rates within certain sectors of educational settings, in general, are elevated, particularly in the elementary and secondary school sectors. The 2019 incidence rates for nonfatal occupational injuries involving days away from work per 10,000 full-time workers

621112 (Offices of Physicians, Mental Health Specialists). These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others. (U.S. Census Bureau, 2022). OSHA requests public comment from SERs on the occupational risk of workplace violence in privately operated correctional facilities and for correctional medical service providers.
per year attributable to workplace violence are:

- Educational Services: 13.3 injuries
- Elementary and Secondary Schools: 25.1 injuries
- Colleges, Universities, and Professional Schools: 1.1 injuries

(BLS Table R-8, 2019)

Although data on the risk specifically to healthcare workers in educational settings are limited, there exists a substantial body of literature on violence to teachers in schools. The risk factors confronting schoolteachers may equally apply to healthcare workers in schools, and data suggest that school counselors, social workers, nurses, and psychologists are frequently the first to see children who are sick, stressed, traumatized, act out, or hurt themselves or others.” (ACLU, 2019).

According to the Report on Indicators of School Crime and Safety: 2020, during the 2015-16 school year, approximately ten percent of public school teachers reported a threat of injury by a student (IES, 2021). A higher percentage of elementary public school teachers than of secondary public school teachers reported a threat of injury (approximately eleven percent vs. nine percent) or being physically attacked (approximately nine percent vs. two percent) by a student (IES, 2021).

In a sample of 1,628 teachers in a southwestern U.S. county, 44 percent of the respondents reported that they were the target of verbal abuse and 34 percent of respondents reported noncontact physical aggression during prior year. (Moon, et al., 2020). In addition, eight percent of teachers in the sample reported at least one physical assault.

OSHA welcomes input from SERs with regard to the risks of workplace violence associated with healthcare services within correctional facilities and educational settings, and the potential need for options that include these employers within the scope of the draft standard.

**Paragraph (c) Workplace Violence Prevention Program (WVPP)**

**WVPP Alternative #1: Conduct review of the WVPP less frequently than an annual review (biennially or triennially vs. annually)**

In the draft regulatory text that OSHA has provided for review by SERs, employers would be required to conduct an annual review of their workplace violence prevention program (WVPP):

(c)(3) Review of the WVPP. The WVPP must be reviewed and updated at least annually and whenever necessary to reflect changes in the workplace, including a change in population, services provided, or the investigation of violent incidents, that indicate a need to revise policies to address employee exposure to workplace violence.

(i) The program review must be conducted by a team consisting of management,
non-managerial employees, and their employee representatives (if applicable).

(ii) Employers must establish and maintain written records for each review
and/or update of the WVPP.

(iii) The team must evaluate records and information pertaining to the
implementation and effectiveness of the WVPP.

OSHA estimates that the cost for affected entities to comply with this provision totals $39.6 million.

OSHA believes that employers conducting regular self-evaluations of their own workplace violence prevention program will result in continuous improvement to implementation. However, OSHA seeks additional information from SERs regarding whether this review could be conducted less frequently without detriment to the functioning of the program or employee safety and what information or factors would warrant such a decrease. To provide a range for cost considerations, employers conducting this review of their WVPP only once every other year (biennially) would reduce the cost by $22.0 million in comparison to annual review – with a percent change of annualized cost of -1.8 percent. For triennial reviews (every three years), the savings would be $26.8 million – with a percent change of annualized cost of -2.2 percent. The annual cost savings per affected employer would be, respectively, $133 and $109.

OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with a requirement that establishments only conduct a formal review of their workplace violence prevention plan every other year (biennially), or every three years (triennially).

**Paragraph (d) Hazard assessment**

**Hazard Assessment Alternative #1: Conduct hazard assessments from workplace violence incident records review for annual hazard assessments from three years of data to just one year or two years of incident data**

OSHA’s draft regulatory text for prevention of workplace violence specifies that employers would be required to review three years of their workplace violence incidents as part of their annual assessment:

(d)(1) Assessment of risk factors throughout the establishment. Each employer must conduct an assessment to identify environmental and organizational risk factors throughout the establishment. The employer must:

(i) Provide an opportunity for employees to report all workplace violence incidents that occurred in the establishment in the previous three years.

(ii) Record all previously unreported workplace violence incidents in the
establishment in the previous three years.

(iii) Review all workplace violence incidents in the establishment in the previous three years.

Here OSHA presents an alternative that employers would only be required to review either one or two years of workplace violence incidents, instead of three years of workplace violence incidents, during each annual hazard assessment. OSHA is interested in how SERs assess their workplace violence and whether they have experience or other information suggesting that that some employers should be able to more quickly declassify a service area from being designated as “high-risk” by reviewing incidents occurring during a shorter period of time. If so, are there particular factors make that shorter period of time appropriate, such as the size or industry of the employer?

OSHA estimates that the savings associated with reviewing just one year of data are estimated to be $5.7 million – with a percent change of annualized cost of -0.5 percent. The savings associated with reviewing only two years of data are estimated to be $2.8 million – with a percent change of annualized cost of -0.2 percent. The annual cost savings per affected employer are, respectively, $28 and $14.

OSHA requests feedback from SERs about how they currently conduct hazard assessments and the benefits or drawbacks that may be associated with a requirement that establishments conduct a review of all workplace violence incidents, including threats of physical harm, which occurred in their establishment within the previous one or two years, instead of three, in their annual review.

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

In the draft regulatory text, OSHA defined high-risk service areas:

*High-risk service areas mean settings where there is an elevated risk of workplace violence incidents. These services and settings include emergency rooms/emergency admissions/triage areas, psychiatric care, behavioral healthcare, substance abuse treatment, home healthcare, social assistance, emergency medical services […]*

Additionally, the draft regulatory text that OSHA has provided in these materials would require employers to identify additional high-risk services areas based on previous occurrence of workplace violence in that area:

*High-risk service areas mean:*
[...]and other services deemed to be of high-risk for violence by the employer. An area where a workplace violence incident has occurred in the previous three years is considered to be high-risk unless the employer has a written determination demonstrating that this designation is not appropriate.

The draft regulatory text, as currently written, would then require employers to conduct additional assessments for a variety of risk factors within these employer-defined high-risk service areas, as indicated by paragraph (d)(vi):

(d)(vi) In addition to the hazards and risk factors in (d)(1)(v), at a minimum, the employer must assess all high-risk service areas, as defined in paragraph (b) for the following risk factors:

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

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

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

The savings associated with this approach is estimated to be $49.3 million, or $244 per affected employer – with a percent change of annualized cost of -4.1 percent.
OSHA would have significant concern with such a framework, since if an employer was experiencing incidents outside of the OSHA-defined high-risk service areas of their establishment, there would be no requirement for the employer to implement the control methods identified in paragraph (e)(3) for high-risk areas. Nonetheless, OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with such a framework.

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

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

OSHA is interested in whether employers might find it equally effective to focus only on those areas where they are experiencing incidents of workplace violence. Accordingly, the regulatory text could differ from what OSHA has provided in this package in the following manner:

*High-risk service areas mean settings where there is an elevated risk of workplace violence incidents. [...] An area where a workplace violence incident has occurred in the previous three years is considered to be high-risk unless the employer has a written determination demonstrating that this designation is not appropriate.*

OSHA estimates that the savings associated with this more focused approach to identification of workplace violence hazards based on employer experience, would amount to $157.3 million, or $780 per affected employer – with a percent change of annualized cost of -12.9 percent.

OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with the ability for employers to designate high-risk service areas for additional controls only based on their own individual experiences and recordkeeping within their
establishment.

**Paragraph (e) Control measures**

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

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

OSHA views this option with significant disfavor, as it would not require a number of control measures that OSHA believes would further reduce the workplace violence hazard. However, OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with this alternative. In particular, OSHA is interested in employer experience with plan development and whether there are specific measures that must be included in a plan to ensure the plan and training provide the same protection for employees that would be provided through specified controls.

OSHA estimates that the savings associated with this approach would amount to $101.7 million, or $504 per affected employer – with a percent change of annualized cost of -8.4 percent.

*Control Measures Alternative #1a: Require that employers implement administrative/work-practice controls only – No requirement for employers to implement environmental or engineering controls.*

Recognizing the potential for cost and the difficulty inherent in making modifications to the built environment, OSHA presents this alternative wherein the employer would not be required to implement environmental or engineering controls. This alternative would instead focus on employers implementing administrative/work-practice controls (adjusting staffing patterns, communication practices, incident response procedures, etc.), developing a workplace violence prevention plan, promoting employee participation, training, recording, and program evaluation.

OSHA estimates that the savings associated with this approach would amount to $94.0 million, or $466 per affected employer – with a percent change of annualized cost of -7.7 percent. OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with
a requirement that employers need only focus on administrative/work practice controls over engineering or environmental controls.

As with the previous alternative, OSHA views this option with significant disfavor, as it would not require engineering control measures that OSHA believes would further reduce the workplace violence hazard. However, OSHA requests feedback from SERs about any perceived benefits or drawbacks that may be associated with the ability for employers to focus solely on developing a workplace violence prevention plan, promoting employee participation, training, administrative/work-practice controls, recordkeeping, and program evaluation. OSHA is interested in whether SERs have any information suggesting that this alternative would be as effective in preventing workplace violence as including the requirements for specific controls.

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

Under this alternative, OSHA could require a clearly defined, limited set of environmental or engineering controls to address a number of specific hazards. Employers would need to conduct a hazard assessment and implement at least one of the controls applicable to the hazard (to the extent that any are applicable), but would not be required to implement all of the controls that could potentially be applicable. For example, if OSHA offers two controls for addressing the potential danger of interactions with patients or clients in a room or area not visible to others, OSHA recommend the installation of closed-circuit surveillance systems, curved mirrors located to allow others to monitor that space, or a personal panic alarm system with nearby staff to assist quickly. The employer must assess the variable in their particular space and select at least one of those controls to address the recognized hazard, but would not need to select more than one even if doing so would provide more layers of protection (e.g., the employer would not be required to install both a closed-circuit surveillance system and a personal panic alarm system with staff nearby).

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

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

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

This alternative would remove the requirement for employers to develop standard operating
procedures for response to mass casualty threats such as active shooters. The draft regulatory text that OSHA has provided in this package for SER review includes a potential requirement under paragraph (e) that states:

(e) Control measures.

(1) Based on the hazard assessments, the employer must establish and implement workplace violence control measures to address identified workplace violence hazards or risk factors. Each employer must:

(ii) Establish and implement effective workplace violence incident response procedures that include, as applicable:

(E) Standard operating procedures to respond to mass casualty threats, such as active shooters

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

OSHA estimates that the savings associated with removing this requirement would amount to $10.0 million, or $49 per affected employer – with a 0.8 percent reduction of the annualized cost.

OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with removing the requirement to develop standard operating procedures for response to mass casualty threats such as active shooters.

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

This alternative would remove the requirement for small entities to develop standard operating procedures for mass casualty threats such as active shooters. However, employers operating establishments that do not meet the criteria of small entity would implement standard operating procedure for mass shooter/mass casualty situations as specified in the draft regulatory text.

OSHA estimates that the savings associated with this alternative would amount to $1.0 million, or roughly $5.50 per affected small-entity employer – with a percent change of annualized cost of -0.1 percent.

OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with removing any requirement for small entities to develop standard operating procedures for response to mass casualty threats such as active shooters. OSHA also requests
feedback on what factors, if any, would make the SBA definition of “small entity” more appropriate than other types of cutoffs (the number of staff expected to be at a location at a given time, the number of staff generally without reference to the revenues of the entity, etc.).

**Paragraph (f) Training**

OSHA considers training to be a vital measure to reduce the risk of workplace violence in healthcare and social assistance. Many comments received in response to the RFI (OSHA 2016-0014) also emphasized the importance of training with respect to preventing workplace violence, and OSHA believes that employee training is an integral component of any workplace violence prevention plan.

OSHA’s draft regulatory text requires that training be provided initially (e.g., by the effective date of this standard), upon hiring, or when existing employees are newly assigned to perform duties for which their previous training did not meet all requirements for the newly assigned duties.

- One tier of training would be designated for employees with direct patient/client/resident contact duties, which are generally higher-risk services. These would be those employees who perform support work that requires them to be in patient care areas – environmental services staff, meal delivery, etc. OSHA has estimated that this may amount to 2 hours of instruction time for employees with direct patient contact duties, as well as their immediate supervisory staff.

- Another tier of training would be designated for employees assigned to direct patient/client/resident care duties in non-high-risk services. These include employees who provide healthcare or social assistance services directly to patients or clients, and have hands-on or face-to-face contact with patients. These employees would include nurses, nursing assistants, patient care assistants, physicians, emergency medical services employees, and social workers providing social assistance services in clients’ homes. OSHA has estimated that this may amount to 4 hours of instruction for employees with direct patient care duties (in non-high-risk service areas) and their supervisory staff;

- A separate and more-advanced tier of training would be designated for employees assigned to direct patient/client/resident care duties in high-risk services. This training would be for the same category of employees as described in the second tier of training, but the distinction would be that they are performing duties within services or service areas that OSHA or an employer has deemed to be high-risk. OSHA has estimated that this may amount to 8 hours of instruction for employees with direct patient care duties (in high-risk service areas) and their supervisory staff;
A fourth and most-advanced tier of training would be required for employees who are reasonably expected to respond to incidents of workplace violence, such as security staff or incident response team members. OSHA has estimated that this may amount to 24 hours of instruction for employees specifically expected to respond to workplace violence incidents and their supervisory staff.

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

This alternative discusses retaining initial training requirements, but removing any requirement for employers to provide annual re-training of employees on the workplace violence prevention measures. For review, Paragraph (f) of the draft regulatory text states:

**(f) Training.**

(1) The employer must institute a training program for employees, who have direct patient/client/resident contact, provide direct patient/client/resident care, or are responsible for workplace violence incident response duties, and their supervisory staff. Training must be provided to these employees at the following intervals:

(i) Initially, prior to the time of assignment, or when newly assigned to perform duties for which the training required in this subsection was not previously provided:
   (A) If an employee received workplace violence prevention training from the employer in the 12 months preceding the effective date of this standard, the employer need only provide additional training to the extent that the previous training did not meet the requirements of this standard;

(ii) Annually thereafter; and

(iii) Supplemental training to address specific deficiencies when:
   (A) There are changes to any procedures or controls designed to address workplace violence. This training may be limited to addressing only these changes;
   (B) Inadequacies in the employee’s knowledge or work practices indicate that the employee has not retained the requisite understanding or skill; or
   (C) Any other situation that arises in which retraining is necessary to ensure employee protection from workplace violence.

Some employers may believe that training is more efficient and cost-effective when it is provided based on their assessment of the capability of their employees, for example, through periodic skills assessments, rather than a requirement to convene routine training on a prescribed schedule. Under this alternative, employees with direct-patient/client/resident care or direct-patient/client/resident contact would only complete an initial training, and, following the initial training, would receive supplemental training only whenever there are significant changes to any workplace violence-related procedures or controls or if employees demonstrate a need for refresher training.
OSHA estimates that the savings associated with removing the requirement for annual employee retraining entirely, would amount to $755.1 million, or $3,744 per employer – with a percent change of annualized cost of -62.1 percent.

Annual training is important, particularly for engaging employees and refreshing knowledge of concepts critical to avoid injury in stressful scenarios. For example, refresher training on de-escalation skills is particularly important to trigger immediate recollection and use of those skills in the heat of the moment of a workplace violence incident when the employee will be under significant stress and decision making will be difficult. Nonetheless, OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with removal of requirements for employers to provide annual re-training of employees on the workplace violence prevention training measures outlined in paragraph (f). OSHA is particularly interested in whether SERS have experience or other information about whether incident-triggered refresher training is as effective as annual refresher training.

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

Under this alternative, only employees with direct-patient/client/resident care and violent incident response duties (e.g., emergency response teams, individual responder duties) would be required to complete training. This draws the same distinction as in the Scope Alternative #1, except that employees in the contact group that would generally be excluded are still covered for training purposes to the extent they are part of group responsible for violent incident response. For review, the draft regulatory text defines these roles as follows:

*Direct patient/client care means job duties that involve the delivery of healthcare services or social assistance services with hands-on or face-to-face contact with patients/clients/residents. Employees who provide direct patient/client/resident care include nurses, physicians, nursing assistants, patient care assistants, technicians, and other healthcare workers, social workers visiting client homes, as well as employees providing emergency medical services.*

*Workplace violence response team means a group of employees designated to respond to violent incidents. They have advanced levels of training and do not have other assignments that would prevent them from responding immediately to an alarm to assist other staff.*

*Individual Responder means an employee designated to respond to workplace violence incidents who has received an advanced level of instruction for response. OSHA expects that a full workplace violence incident response team may not be necessary for some nursing homes, certain social assistance settings, group homes or similar settings, but rather that an individual responder could be sufficient to assist employees with de-escalation of workplace violence incidents.*
Under this alternative, employees who have direct-patient contact (i.e., physically close to patients when performing duties), but who are not responsible for direct-patient care, would not need to receive workplace violence prevention training. For review, the draft regulatory text defines “direct patient/client/resident contact” as follows:

*Direct patient/client contact means job duties where employees perform support work that requires them to be in patient care areas. Such work includes environmental services, engineering services, laundry services, meal delivery, information technology, and others.*

For the purposes of SBREFA, security employees have been designated as patient contact employees.

OSHA estimates that the savings associated with removing the training requirement for direct patient/client/resident contact employees would amount to $19.7 million – with a percent change of annualized cost of -1.6 percent.

OSHA requests feedback from SERs about perceived benefits or drawbacks that may be associated with this alternative to require training only for employees who provide direct-patient/client/resident care or designated as workplace violence incident response team members or individual responders and removing the training requirement for employees who have direct-patient/client/resident contact.

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

As explained above in Training Alternative #1, refresher training is particularly important to trigger appropriate employee responses during stressful incidents and OSHA has proposed annual refresher training for this purpose. Nevertheless, OSHA has identified the alternative of requiring employers to provide refresher training for all tiers of employees only every 3 years instead of annually.

OSHA estimates that the savings associated with this reduced periodicity of training (every three years instead of annually) of would amount to $510.8 million, or $2,532 per affected employer – with a percent change of annualized cost of -42.0 percent.

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

OSHA is interested to hear SERs about perceived benefits or drawbacks that may be associated with a requirement for refresher training to be provided every three years or every two years instead of every year and if SERS have experience or other information about whether triennial...
refreshers, or refreshers of other frequencies, are as effective as annual refresher training.

*Training Option #1: Require advanced training for employees working in very small facilities (≤2 employees on site)*

This option would require an advanced level of instruction for all employees working in an establishment with only one or two employees on site (e.g., small behavioral health group home). These employees are likely to be less able to coordinate with other employees in order to respond to incidents of workplace violence so it may be that all employees at these establishments need advanced training in order to respond to those incidents. OSHA believes that frequently these employees may receive guidance to call 911 to deal with issues of workplace violence, however under this option, these employers would be required to provide advanced training so that employees know how to respond to workplace violence incidents. Under this alternative, 25,025 establishments (employing 48,823 employees) with two or fewer employees would get the advanced training (estimated to be 24 hours), out of 129,788 very small entities with fewer than 20 employees.

As specified previously, OSHA preliminarily estimates that employers would provide 24 hours of instruction for both employees and their supervisory staff when those employees are reasonably expected to respond to incidents of workplace violence. For employees who may be less able to coordinate with other employees in order to respond to incidents of workplace violence, this added level of training would result in an enhanced aptitude for responding to incidents in these situations.

OSHA estimates that the cost associated with training two employees under this training option would amount to $14.1 million, or $109 per affected very-small-entity employer – an increase in annualized cost of 1.2 percent.

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

OSHA is interested to hear from SERs about perceived benefits or drawbacks that may be associated with this additional training requirement for employees who are specifically designated to respond to incidents of workplace violence. In addition, OSHA is interested in SER feedback on a potential exception to this additional training requirement for very small facilities (≤ 2 employees on site).

*Training Sensitivity Test #1: Reduction of estimates of training length for the most advanced level of employee workplace violence prevention training*
The draft regulatory text that OSHA has provided has not prescribed any specific length of time that would be associated with the various tiers of employee training curricula. However, OSHA has provided some estimates in these supplementary materials, and assumes that employees receiving the most advanced level of training will receive 24 hours of instruction. The highest tier of training, designated for those employees expected to respond to workplace violence incidents (and their supervisors) would remain the most extensive. Under this sensitivity test, however, OSHA estimates that employees could receive adequate instruction from a curriculum of 8 hours of training, rather than 24 hours. That instruction would still be different from the training received by Tier 3 employees and would focus more on the knowledge required for individuals who are responsible for responding to workplace violence incidents.

Because the agency places great emphasis on the importance of training, OSHA believes that 8 hours may not be sufficient to ensure employees have the knowledge to respond to workplace violence incidents. Nonetheless, OSHA is interested to hear from SERs about OSHA’s training estimates and the amount of training needed to ensure employees have the knowledge and skills to respond to workplace violence incidents.

OSHA estimates that the savings associated with these reduced training hour estimates would amount to $19.8 million, or $98 per employer – with a percent change of annualized cost of -1.6 percent.

**Paragraph (g) Violent incident investigation and recordkeeping**

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

This alternative would require a post-incident investigation only if the workplace violence incident involved a physical assault (i.e., not if the incident was only a threat of physical assault). Under the draft regulatory text, all workplace violence incidents must be investigated. According to the definition of workplace violence incident provided in this draft standard:

*Workplace violence incident* means any violent act (including physical assault and threat of physical assault) directed toward persons at work or on duty by patients or their visitors. *It may or may not result in injury.*

OSHA understands that given the nature of some healthcare and social assistance services covered within several sectors in the scope of this draft standard, there may be patients or clients who issue verbal or present physical threats regularly due to emergent health conditions and/or mental health crises, and it may be challenging and time-consuming for employers to investigate every threat. OSHA also acknowledges that the most pressing type of incident to investigate are those that involve physical assault. By limiting investigations to incidents of physical assault, employers may be able to focus on the highest-risk incidents.
To estimate the cost savings for this alternative, OSHA removed cases of non-lost-workday (non-recordable) incidents (see Table 3) from the body of events that would trigger an investigation. OSHA estimates that the savings associated with this violent incident investigation alternative would amount to $13.7 million, or $68 per affected employer – with a percent change of annualized cost of -1.1 percent. The result is an overestimate of the savings because some of those removed cases involved actual physical injury, not just threats, even if that injury was not significant enough to warrant a lost workday. OSHA is not aware, however, of an alternative method that would provide more accurate results.

OSHA estimates that, out of 619,000 incidents investigated for all reasons, this regulatory alternative results in a 38 percent reduction in investigations, or 232,000 fewer investigations. Under this alternative, employers would investigate all workplace violence incidents except for those exclusively involving threats.

OSHA is interested to hear from SERs about perceived benefits or drawbacks that may be associated with requiring violent incident investigations to be conducted only for workplace violence incidents associated with a physical assault.

OSHA also invites comment from SERs on an expansion to this Recordkeeping Alternative #1 that would require a post-incident investigation only if the workplace violence incident involved care beyond first aid. For example, if the employee does not require any care (e.g., they experienced minor scratches/bruising), no investigation would need to be conducted by the employer.

OSHA views this expansion to Alternative #1 with disfavor, as many workplace violence incidents result in injuries that may not rise beyond the need for first-aid yet may still inflict emotional and psychological injury. Such incidents may be the result of an incident that rose above the threshold of a near-miss, however more significant injury was only narrowly averted and could have been much worse. The investigation of these seemingly less severe incidents may help to prevent future injuries and fatalities. Nonetheless, OSHA is interested to hear from SERs about perceived benefits or drawbacks that may be associated with only requiring violent incident investigations for workplace violence incidents that result in injuries that exceed those of first-aid.

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

Under this option, employers would provide post-incident medical and mental health evaluations
and treatment for the affected employee for a period not to exceed one year, at no cost to the employee. This option would require post-incident medical treatment and mental health evaluations only if the workplace violence incident involved care beyond first aid (i.e., minor cuts/scratches). Of 619,000 violent incidents in the workplace, OSHA estimates that eight percent, or 49,520 violent incidents, require treatment beyond first aid. If the employee does not require any care beyond first aid, the employer need not provide medical treatment and mental health evaluations.

Time associated with an employee receiving post-incident medical and mental health evaluations/treatment, and reasonable travel time (as appropriate) shall be considered compensable time. Under this option, OSHA has assumed one hour of evaluation per week for one year, with $5 of travel time per session. For WPV recordable, lost-workday incidents, the costs of post-incident medical treatment and/or mental health evaluations will total $108.7 million ($539 per affected employer), raising total costs for the WPV regulatory framework to $1.32 billion. For WPV recordable non-lost-workday incidents, the costs of post-incident medical treatment and/or mental health evaluations will total $231.6 million ($1,148 per affected employer), raising total costs for the WPV regulatory framework to $1.45 billion. Estimation of total cost is based on average annual per-employee cost of $2,200 applied to estimated OSHA recordable incidents. This estimate is also based on an assumption that all affected employees would use one full year of weekly counseling. OSHA believes this may be a significant over-estimate of affected employees who may wish to engage in such post-incident services, or may wish to engage in post-incident services for a full year. Based on a review of recent employee assistance program literature, OSHA observes that employee utilization of employer assistance programs ranged from 2.1 percent to 8 percent from 2015 to 2018 with an increased demand for services treating anxiety or stress during the COVID-19 pandemic.\(^{48}\) OSHA is interested to hear SERs input on this option that would require employers to offer post-incident medical and psychological evaluations and treatment, as well as the experiences of SERs who may already offer such services, and how frequently affected employees currently make use of such services.

**Paragraph (j) Effective Date of the Standard**

OSHA has presented multiple over-arching regulatory components in this informational package. These include elements of paragraphs:

- (c) Workplace Violence Prevention Program (WVPP);
- (d) Workplace violence hazard assessment;
- (e) Control Measures;
- (f) Training;

\(^{48}\) Brooks and Ling (2020) found that utilization of services treating anxiety and stress increased during the COVID-19 pandemic, but that overall utilization of these services declined between the first and second quarter of 2020. See also SHRM, 2019, and Chestnut Global Partners, 2016.
Paragraph (j) Effective Date of the draft standard states that all provisions would become effective 60 days after publication, and that all employers would need to comply with all provisions within six months after publication. OSHA estimates that many employers would not have significant difficulty coming into compliance in six months.

OSHA welcomes information from SERs regarding which, if any, of the draft provisions would be difficult for small entities to comply with within six months, and why it would be difficult. For those provisions that SERs believe warrant a longer period of time for compliance, OSHA welcomes input on whether nine or twelve months is needed to comply, and the reasons for additional time.

General Alternative: OSHA opts to take no action on this draft standard on Prevention of Workplace Violence in Healthcare and Social Assistance, and continues to address workplace violence hazards in healthcare and social assistance solely through use of the General Duty Clause.

OSHA could decide not to promulgate a new rule addressing workplace violence in the healthcare and social assistance sector. Instead, OSHA could continue to protect employees from this hazard through enforcement of the OSH Act’s General Duty Clause (29 U.S.C. 654(a)(1)). The General Duty Clause requires “[e]ach employer” to “furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees” (id.).

As described in more depth in Section III, Reasons Why Action is Being Considered by OSHA, OSHA does not believe this approach would adequately protect workers in the healthcare and social assistance sectors from the risks of workplace violence. The General Duty Clause is typically more difficult to enforce than a standard and it is a less comprehensive approach to addressing the workplace violence hazard because it does not specify the actions employers must take to reduce the hazard. In that sense, a workplace violence standard also provides more notice to employers about the steps that must be taken to address the hazard.

Furthermore, OSHA received two workplace violence rulemaking petitions in 2016, one from a coalition of labor organizations (American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), American Federation of Government Employees (AFGE), AFSCME, SEIU, Teamsters and United Steelworkers, and American Federation of Teachers (AFT)), and the other from the National Nurses United (NNU). OSHA granted the rulemaking petitions on January 10, 2017, stating that “workplace violence is a serious occupational hazard that presents
a significant risk for healthcare and social assistance workers” and that a workplace violence standard “is necessary.” Discontinuation of the rulemaking process would likely subject OSHA to additional litigation. Nonetheless, OSHA would be interested to hear from SERs about perceived benefits or drawbacks that may be associated with an option where OSHA takes no rulemaking action with regard to prevention of workplace violence in healthcare in social assistance, and simply continues to address workplace violence hazards through the General Duty Clause.

REFERENCES


BLS Table S8, April 2016; (OSHA-2016-0014-0063).


OSHA 5(a)(1) Citation - Willful Violation Detail (2014) Corizon Health Inc., Correctional Medical Associates of NY, Correctional Dental Associates of NY | Occupational Safety and Health Administration (osha.gov)

OSHA Compliance Directive CPL 02-01-058: Enforcement Procedures and Scheduling for
