April 6, 2017

The Honorable Dorothy Dougherty
Acting Assistant Secretary
Occupational Safety and Health Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

RE: ASSE Comment on OSHA Request for Information Concerning Prevention of Workplace Violence in Healthcare and Social Assistance, OSHA Docket 2016-0014, Regulatory Information Number (RIN) 1218-AD 08

Dear Acting Assistant Secretary Dougherty:

The American Society of Safety Engineers (ASSE) is pleased to submit the following comments concerning the Occupational Safety and Health Administration’s (OSHA) Request for Information Concerning Prevention of Workplace Violence in Healthcare and Social Assistance, published in the December 7, 2016, Federal Register (81 Fed. Reg. 88147) ("RFI"). ASSE is the oldest and largest society of safety professionals in the world. Founded in 1911, ASSE represents more than 37,000 dedicated safety, health, and environmental professionals. Our members are experts in managing workplace safety and health in every industry, in every state, and across the globe. They belong to one or more of ASSE’s many practice specialties. ASSE is also the Secretariat for various voluntary consensus standards related to best practices in occupational safety and health.

ASSE’s Healthcare Practice Specialty (HPS) addresses the occupational safety and health of those working in the healthcare industry, including hospitals, extended-care facilities, medical clinics, doctors’/dentists’ offices and related fields, such as psychiatric facilities, substance abuse facilities, paramedic operations and industries providing goods or services to medical facilities. HPS members help identify and promote research in emerging healthcare safety technologies and develop specialized healthcare safety education programs and technical materials.
We commend OSHA for taking up this critical issue and appreciate the opportunity to share our members’ expertise. Broadly, our members recommend OSHA refrain from engaging in WV rule making other than in the healthcare and social assistance arenas, relying on the General Duty Clause in the cases that enforcement is needed in other sectors. We recommend OSHA harmonize with Cal-OSHA in defining workplace violence, particularly noting that OSHA’s jurisdiction does not cover racial, ethnic, religious, or sexual harassment etc. because those are civil rights issues. We include for reference a letter from ASSE’s Healthcare Practice Specialty newsletter on a systematic approach to preventing WV. Finally, we remind OSHA of the connection of WV to the issue of public sector worker coverage and hope OSHA will join ASSE in supporting pending legislation that would effectuate this coverage, HR 914, Protecting America’s Workers Act.

**General Comments**

ASSE's HPS members are directly affected by any proposed Workplace Violence (WV) rulemaking applicable to Healthcare and Social Assistance (HC & SA), and have provided input for this informational response. We have encouraged them to provide individual input as well, as this initiative proceeds, because they have the data and experiences OSHA seeks in the RFI.

This is true with respect to most of the questions posed in the RFI, which pertain to employer experiences with state-specific requirements and individualized experiences with development and implementation of WV programs responsive to these state mandates, site-specific compliance burdens in terms of staff hours, data tracking etc. ASSE, as a professional society, at this time can only provide information relevant to overarching approaches to regulation and the more general questions posed in the RFI.

As OSHA correctly notes in its RFI, WV impacts a wide range of HC & SA workplaces, including psychiatric facilities, hospital emergency departments, community mental health clinics, treatment clinics for substance abuse disorders, pharmacies, community-care facilities, residential facilities and long-term care facilities. Both hourly and salaried employees, as well as contractors and temporary personnel, can be adversely affected by WV during healthcare and social services activities.

**Scope of Applicability**

The scope of any HC & SA sector-specific rule should be expansive, so that all workers at risk of workplace violence are protected by the employer's programs and policies, regardless of whether they are rank and file workers or professional medical or administrative personnel. ASSE does agree, however, that at this time any binding rule should be limited to the healthcare and social assistance sectors, rather than covering all worksites. For those other sectors, employers should be encouraged to utilize OSHA guidance on workplace violence, and for workplaces with recognized risks of violence that are not mitigated, enforcement through Section 5(a)(1) of the OSH Act, the "General Duty Clause," remains an option for the agency on a case-by-case basis.

There is no question that workplace violence is a recognized occupational safety hazard in certain industry sectors, particularly when the causal factors arise in relation to the nature of the work. We recognize that any business can be unforeseeably impacted by harm to employees arising from outside sources, or by violent actions from disgruntled employees or because of domestic violence.
Some other sectors are at heightened risk of other types of violent acts arising from criminal activities, such as robberies of banks, taxi drivers, convenience stores and other late night establishments, as well as in businesses that might have intoxicated patrons or those located in high crime or gang activity areas. These incidents do occur but are relatively infrequent. OSHA has already provided valuable guidance on preventative measures that can be considered by these employers and can be integrated into existing occupational safety and security programs.

Where such employers have a reason to know of specific threats to worker safety, and fail to implement feasible protective actions, OSHA has recourse to issue citations under its General Duty Clause (GDC), Section 5(a)(1) of the Occupational Safety and Health Act of 1970. The maximum penalty for willful violations is $126,749.

While it is recommended practice to anticipate emergency situations, plan and drill, so that all workers know how to respond in one of the scenarios described above, an OSHA standard covering the broad universe of employers would probably be impractical to design or enforce.

There also must be consideration of workplace violence threats affecting (or arising from) other on-site personnel such as temporary workers and contractors, how emergency protocols can best be communicated to these short-term personnel, and how contractors or other contingent workers can be prequalified, or otherwise adequately monitored, to ensure that they do not pose a threat to the host company or facility’s employees.

The problem with using the GDC as the main enforcement tool to address WV issues is simply that it is reactive in virtually every situation. While OSHA investigates fatalities and cases with severe injuries that must be reported by law, it is virtually unheard of for OSHA to investigate an employer concerning workplace violence prevention before a tragic incident occurs, unless triggered by a publicized "near miss" such as a thwarted robbery covered in the media, or due to an employee hazard complaint. Lesser injuries escape OSHA scrutiny entirely in most cases.

However, while prevention of WV-related injuries should be of concern in all industries, in those sectors where incidence rates are relatively low, use of guidance coupled with enforcement through the GDC is probably sufficient at present.

At this time, OSHA should refrain from engaging in workplace violence rulemaking, other than for the HC & SA arena. ASSE does encourage OSHA to continue to review and improve its workplace violence prevention guidance for other “at risk” sectors, such as late night establishments.

**Rulemaking for Healthcare and Social Assistance Industries**

While the GDC enforcement approach may work for most low-risk industries, it is a different story in the HC & SA sectors. Statistics show that WV-related injury rates for this sector were 8.2 per 10,000 full time workers. This is more than four times higher than the overall private sector incidence rate for such injuries. This is simply unacceptable when interventions are available to mitigate risk.

The types of WV threats, and types of desired responses, can be variable depending upon the role of the staffer (e.g., a security officer at a hospital will need different training and response protocols than would an orderly or a nurse). Another challenge in crafting mandatory regulations will be the need to
reflect that, often, WV threats or incidents arise outside of the employer’s direct control, such as when health care or social service workers conduct their activities at a patient or client home, or the home of a third party where the patient/client resides. In most cases, it will be outside the ability of the employer to conduct a true risk assessment in situations such as this, where it may not be foreseeable to predict who may be present in the setting in addition to the patient/client (such as family members with violent propensities).

The overall rate for violent injuries in the SA sector is 9.8 per 10,000 FTW. In certain HC sectors, worker injury rates from WV can range from 11 times higher (nursing and residential care facilities) to 64 times higher than the overall rate (psychiatric hospitals). What differentiates WV in these two sectors from other industries is that the HC & SA workers are more likely to be injured by patients rather than clients (or their family members), arising directly from their assigned work activities as opposed to violence due to random acts of outsiders. Therefore, such hazards are both recognized and foreseeable. ASSE believes that, with proper programs and training developed and implemented pursuant to an industry-specific OSHA workplace violence standard, they are also preventable.

There is no need for OSHA to start from scratch developing a rule, as it already has a plethora of guidance materials developed by the agency, and by third party organizations on this subject. We hope that OSHA will research out to the main accrediting bodies for the health care sector, to gain their input and perspective on any new requirements: The Joint Commission, Healthcare Facilities Accreditation Program, and Det Norske Veritas Healthcare, Inc.

OSHA should also work closely with the National Institute for Occupational Safety & Health (NIOSH), which conducts research on occupational safety and health hazards to inform OSHA’s regulatory decisions, on both this rulemaking and future guidance and to identify future research areas of benefit.

As noted below, there are already nine states with mandatory WV rules for these vulnerable industries, and most Canadian providences, as well as the Canadian federal government, have added WV programmatic requirements to their regulations.

These resources can form the basis for a strong and effective OSHA standard. To have a legally enforceable rule, it is probably prudent to limit the scope of the standard to incidents that are truly within the employer’s control, e.g., those arising from interface with patients/clients and associated family or household members, rather than the random violent or criminal acts of strangers. In addition, to limit the subjectivity of enforcement and problems of fair notice and due process, any standard must be precise concerning which actions or threats would be covered by the standard.

California, which runs a state plan OSHA program covering both private and public sector workers, recently adopted a WV standard for healthcare, in something of a negotiated rulemaking negotiated between labor, industry and the State. Logging of WV incidents by healthcare providers will be required starting in April 1, 2017, and the logs will be posted on the State website. The Cal-OSHA standard covers the following sectors, all determined to be part of “healthcare”:

- Health facilities, as defined below:\1

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1 “Health facility” means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, or treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer. (Ref: Health and Safety Code Section 1250). For the purposes of this section, a health
• Home health care and home-based hospice;
• Emergency medical services and medical transport, including these services when provided by firefighters and other emergency responders;
• Drug treatment programs; and
• Outpatient medical services to the incarcerated in correctional and detention settings.

Harmonization with Cal-OSHA
Federal OSHA should consider harmonizing with the Cal-OSHA definitions in its rule:

“Workplace violence” means any act of violence or threat of violence\(^2\) that occurs at the work site. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:

(A) The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;

(B) An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;

(C) Four workplace violence types:

1. "Type 1 violence" means workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
2. "Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient.
3. "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager.
4. "Type 4 violence" means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.

Aside from consideration of inclusion of definitions developed in the Cal-OSHA rule, ASSE recognizes that some covered entities and their workers may need more specific guidance on what might fall within these categories, and this is difficult because of the varying nature of HC & SA activities – some of which are much higher risk than others.

If OSHA will provide guidance it may consider listing the following as indicia of workplace violence risks, so that employees will have improved hazard recognition and situational awareness:

\(^{2}\) “Threat of violence” means a statement or conduct that causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured, and that serves no legitimate purpose.
• Threatening behavior: shaking fists or fingers at employees, destroying property, throwing objects, or even theft of personal property in the workplace;
• Verbal or written threats: social media or telephone/email threats, or any other written or verbal expression of an intent to inflict harm; and
• Physical attacks: hitting, biting, spitting, shoving, pushing, kicking, rape, arson, assault, or murder.

While some might consider other types of harassment to be within the definition, we disagree but do suggest that training be given as a best practice to ensure that employees are barred from engaging in any behavior that demeans, embarrasses, humiliates, annoys, alarms or verbally abuses a person, and that is known or would be expected to be unwelcome. This includes words, gestures, intimidation, bullying or other inappropriate activities. It is outside OSHA’s jurisdiction to address racial, ethnic, religious, or sexual harassment and other types of hostile work environments that fall more properly within the scope of the EEOC’s enforcement of civil rights laws.

We do support including home health care services within the scope of the standard as well as threats or actual workplace violence situations that arise from work-related business functions (on-site and off-site).

While many employers do take a “zero tolerance” approach to workplace violence, in terms of their disciplinary programs, ASSE believes that this should not be mandated by OSHA as it is a matter for collective bargaining or consideration as part of a total human resources program.

As far as other mandatory program elements, ideally the WV components can be integrated into an existing safety and health management program, with elements specific to WV added. In the Cal-OSHA rule, the new workplace violence prevention elements must be included in employers’ already-mandated Injury & Illness Prevention Programs (IIPP). Although federal SHA lacks a mandatory “I2P2” due to the apparent abandonment of that rulemaking initiative, many larger and proactive companies do so voluntarily by following the approach suggested in the ANSI Z-10 national consensus standard, or in OSHA’s recently updated guidelines. Other employers adopt such programs as a result of corporate-wide settlement or abatement terms, which makes the program elements enforceable thereafter.

ASSE supports a mandatory programmatic WV standard, rather than voluntary guidelines, to address workplace violence in the HC & SA sectors only. It should be based on the standard hierarchy of controls, with requirements for written programs and policies, documented training, standardized definitions, reporting requirements to include fatalities, injuries and illnesses arising from workplace illness incidents (including Post Traumatic Stress Disorder and other mental health conditions arising from any assault, as well actual physical injuries), risk assessment and hazard control. There should be provisions for management involvement and oversight, as well as employee participation.

ASSE has included, as an attachment to these comments, an article from ASSE's HealthBeat newsletter (by Cory Worden, CSP, CSHM, CHSP, R.E.M., CESCO, 2015) entitled Preventing Workplace Violence. We ask you to include it in the rulemaking record, as it focuses on the subject industries and outlines some best practices for evaluating and addressing conditions and behaviors that relate to workplace violence threats.
Public Sector Worker Coverage
Because the scope of workplace violence directly includes personnel in the social services and healthcare sectors who are employed by state, county and municipal government agencies or healthcare facilities (such as medical clinics at prisons and public mental health facilities or social workers who investigate domestic violence and child abuse allegations), ASSE is very concerned that these workers will remain unprotected and at high risk of injury.

Currently, federal OSHA lacks jurisdiction over such public workers, although the 21 OSHA programs run by individual states must cover public sector employees in order to be approved, and 5 other "federal OSHA" states have their own state-run programs covering public sector workers. Two US territories, Puerto Rico and the US Virgin Islands, also cover public sector workers.

It is notable that, of the nine states that have independently enacted laws requiring employers with HC & SA workers to establish a plan or program to protect them from WV, all but Maine are among those with public sector worker protections. Unlike the other states, Maine's rule lacks both a risk assessment component and a training requirement, both of which are essential elements of any effective WV rule or program. The other states with WV program requirements are: California, Connecticut, Illinois, Maryland, New Jersey, New Harold, Oregon and Washington. As part of this rule making, OSHA should seek input from those states on both their experiences with regulation and enforcement, and use the most effective elements from each as the basis for a cohesive rule that can be applied nationwide.

In the remaining 24 federal OSHA states, unfortunately, publicly employed social services workers and healthcare workers will continue to lack WV protections, even if federal OSHA eventually promulgates a binding rule, and any severe injuries or fatalities arising from WV affecting these public sector workers will not be reported to nor investigated by federal OSHA.

ASSE has long been a proponent of expanding federal OSHA coverage to protect all public sector employees and we encourage OSHA to join in supporting pending legislation that would effectuate this coverage, HR 914, Protecting America's Workers Act.

Most of OSHA's data are from private sector employers, but these occupations are also commonly held by public sector workers, including those who work as social workers, child protective services, and at state or county run medical facilities. Even where some of these positions are contracted out by the state or municipal agency to a private employer, the government still functions as the "host employer" and will be best positioned to identify security needs and protocols, and for communicating those to its contractors who could be affected by WV while at the host facility.

OSHA should strive, as part of any future rulemaking, to gather data on public sector incidence rates for HC & SA workers to ensure that these workers will have equal protection under the law. The 26 state plans covering public sector workers may be a source of this information.

The Canadian Experience
The RFI sought information on resources and model programs that should be considered when formulating a rule. In addition to many valuable resources listed in the RFI, it may be useful to consider how Canada addresses the issue of workplace violence from an occupational safety and health
perspective. Most provinces have guidance or binding requirements on this subject, in addition to the overarching federal requirements under the Canada Occupational Safety and Health Regulations.

The Canadian WV requirements are not limited to the healthcare and social services sector, although these are identified as areas with high incidence rates, nor do the requirements limit workplace violence threats to those arising from occupational interfacing with patients or clients. Ontario published a workplace violence guide in September 2016, explaining its WV requirements, that is a good model for prospective standards. [https://www.labour.gov.on.ca/english/hs/pubs/wpvh/index.php](https://www.labour.gov.on.ca/english/hs/pubs/wpvh/index.php).

Under Ontario's Occupational Health and Safety Act, providing a workplace free from violence is covered under the Canadian General Duty Clause, but its law mandates further elements relating to workplace violence. Those rules provide, in relevant part:

*Every employer ... must prepare and review, at least annually, a policy on workplace violence, as required by the OHSA. This policy is required regardless of the size of the workplace or the number of workers. If six or more workers are regularly employed at a workplace, this policy must be in writing and posted in a conspicuous place in the workplace. If fewer than six workers are regularly employed at the workplace, the policy does not necessarily have to be written. However, a Ministry of Labour inspector may order the policy to be in writing.*

The Ontario rules further specify that the workplace violence policy should:

- show an employer’s commitment to protecting workers from workplace violence;
- address violence from all possible sources (customers, clients, employers, supervisors, workers, strangers and domestic/intimate partners);
- outline the roles and responsibilities of the workplace parties in supporting the policy and program; and
- be dated and signed by the highest level of management of the employer or at the workplace as appropriate (examples may include, but are not limited to, the President, Chief Executive Officer, senior human resources professional or uppermost member of management at the workplace).

Workplace violence risk assessment is a duty of these employers, and the law states that the employer has several responsibilities for assessing the risks of workplace violence and must:

- assess the risk of workplace violence that may arise from the nature of the workplace, type of work or conditions of work;
- consider the circumstances of the workplace and circumstances common to similar workplaces, as well as any other elements prescribed in regulation; and,
- develop measures and procedures to control identified risks that are likely to expose a worker to physical injury. These measures and procedures must be part of the workplace violence program.

Canadian employers must also advise a joint health and safety committee or health and safety representative of the assessment results. If there is no committee or representative, the employer must advise workers of the assessment results. Employers must repeat the assessment as often as necessary.
to ensure the workplace violence policy and related program continue to protect workers from workplace violence.

**Conclusion**

ASSE commends OSHA for engaging in this RFI to compile data and take initial steps toward an effective workplace violence standard that will protect the many at-risk workers in the HC & SA industries. We pledge our assistance in working with the agency to develop an appropriate standard that will be both feasible and effective in the future. Thank you for your consideration of our position.

Respectfully submitted:

Thomas F. Cecich, CSP, CIH