Submitted Electronically

April 7, 2023

Andrew Levinson
Director, Directorate of Standards and Guidance
United States Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Re: **Prevention of Workplace Violence in Healthcare and Social Assistance**
Docket No. OSHA-2016-0014

Dear Mr. Levinson:

LeadingAge appreciates the opportunity to offer comments relating to OSHA's consideration of a potential standard relating to Prevention of Workplace Violence (WPV) in Healthcare and Social Assistance.

We recognize and appreciate the importance of protecting workers from acts of violence committed by individuals receiving services and offer the following comments to share perspective on the issues OSHA is considering and how the framework it has developed may impact providers across the continuum of aging services.

Our comments have been informed by input from member organizations and our reflections on the feedback provided by Small Entity Representatives (SER) as part of the recent Small Business Advisory Review (SBAR) panel meetings. We have sought to tailor our comments to the specific purposes for which OSHA has requested additional feedback, namely evaluation of technical feasibility and cost estimates relating to compliance with these potential standards.

A. General Comments

If OSHA proceeds to rulemaking, we believe certain general principles should guide the agency's work, and we offer selected examples below relating to these themes.

One Size Does Not Fit All. Any OSHA standard relating to WPV must reflect the significant diversity of employers that would be covered by it. As many SER participants noted during the SBAR panel meetings, a one-size fits all approach would not be appropriate.

The first level of diversity to consider is the wide range of healthcare or social assistance provider types that would be included. A standard that might make sense for hospitals might very well not make sense for an aging services provider, for example.

These distinctions are especially important when considering that aging services are provided to individuals in their homes. This is true for community-based providers, such as home health agencies, and for providers offering living spaces in congregate settings, such as nursing homes,

assisted living facilities and continuing care retirement communities, all of which make it their mission to create, maintain and foster a supportive home-like environment for those they serve.

Further, significant diversity will exist within any given category of covered employer, in terms of the size of the organization, its resources and capacity to implement regulatory requirements, the services the specific organization provides and the specific characteristics and needs of the population it serves, the service delivery setting (congregate residential care settings vs. community-based care and services such as adult day programs and home health), and geography (i.e. rural versus metro). Assisted living offers one good example of this issue of diversity across providers within a given category. Such providers may vary greatly in size, from small residential settings serving fewer than ten individuals, to much larger buildings serving one hundred or more residents. Also, states across the country define these settings differently for purposes of licensing, including defining the level of care that may be delivered to individuals within a licensure category.

If OSHA proposes a standard, it should recognize these and other aspects of organizational differences, both in terms of the substance of the potential requirements and in OSHA's evaluation of the feasibility and impact of proposed requirements at this pre-rulemaking stage of work.

OSHA Standards Should Provide Flexibility. We believe certain aspects of the proposed regulatory framework are more prescriptive than necessary and recommend that OSHA consider more general requirements if it proceeds to rulemaking, with greater flexibility granted to employers to design programs tailored to their specific organizations. We offer some specific examples where we believe greater flexibility is needed in the material below.

During the SBAR panel meetings, staff from OSHA noted the need to strike a balance between providing flexibility to employers and making clear what steps an employer must take in order to achieve the goal of worker safety. We understand this, including the need for consistency in interpretation, application and enforcement of the standard by federal and state OSHA inspectors. Given the diversity issues noted above, however, as well as the complex challenge of identifying what specific measures are most likely to reduce the incidence of WPV events, we recommend that OSHA provides flexibility when possible.

We Urge OSHA to Avoid Duplication of Existing Requirements

A common view expressed by the Small Entity Representatives during the SBAR panel meetings was that OSHA should not duplicate requirements that employers already meet under federal certification or state licensing requirements, conditions of payment through State Medicaid programs, or pursuant to standards applied by accrediting organizations. We agree and wish to emphasize the importance of this point.

When more than one regulatory agency establishes requirements relating to the same activity, additional work and related cost can result for the regulated entity. This may arise when two agencies establish similar but not identical requirements or where they establish conflicting requirements. Even where two standards are conceptually aligned (conduct a facility assessment, for example), differences in content, process, or other factors can create significant operational complexity.

While not exhaustive, the following are examples of existing licensing and certification requirements that address certain aspects of OSHA's working framework for a WPV standard:

- Emergency Preparedness. Medicare-certified provider and supplier types are required to comply with federal emergency preparedness requirements. Among these requirements are obligations to establish and maintain a written preparedness plan that is based on and includes a documented, facility-based and community-based risk assessment that considers all risks or emergencies that the provider facility may reasonably expect to confront.
- Person-Centered Care Planning and Service Delivery. As a matter of best practice, and as required under state licensing, and federal certification or accreditation standards where applicable, aging services providers assess the medical, psychosocial and other needs of all individuals they serve, develop care- or service-plans to meet those needs through positive support, update those care delivery plans as new services or tailored interventions are needed, and regularly train and communicate with staff regarding the delivery of services and supports. State and federal requirements also include expectations (which may be referred to as abuse prevention planning) for evaluating risks that an individual receiving services may present to others.
- Nursing Homes' Facility Assessment: In addition to emergency preparedness requirements, CMS regulations require nursing facilities/skilled nursing facilities to conduct a facility-wide assessment that includes the needs of the individuals being served, staff competencies, and risks that the facility may face in its operations and delivery of care.
- Building Requirements. State codes, as well as federal regulations such as CMS's requirement that nursing facilities/skilled nursing facilities comply with the NFPA Life Safety Code, address certain physical plant issues that may overlap with issues OSHA is considering. Also, CMS regulations require that a nursing facility/skilled nursing facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

We noted OSHA's effort during the SBAR panel discussions to understand what work organizations are already doing in relation to risks of workplace violence, and we urge OSHA to undertake additional study of existing requirements and oversight systems in place from other agencies as this work proceeds and to consider how compliance with certain of these requirements might be deemed sufficient for purposes of complying with an OSHA standard.

B. Cost Estimates

In its background materials OSHA specifically requests feedback on whether its initial estimates of the costs for implementation of the proposed framework are accurate and appropriate. On this point, we would offer three general comments.

- First, we noted that a number of SER participants in the SBAR panel process expressed that OSHA has under-estimated the staff time that would be required to complete certain aspects of the proposed framework. We defer to the SBAR panel report for a compilation of that feedback, knowing that OSHA will consider it seriously.

- Second, we noted that OSHA is using 2017-2019 data relating to wages and employer compensation costs in some respects, for purposes of monetizing the estimated labor burden relating to compliance with the framework. We ask OSHA to review updated data, given the rapid and significant wage inflation that has recently occurred within aging services and across healthcare, as a result of the COVID-19 pandemic and historical workforce shortages in our sector. Reporting on findings from a 2022-2023 Hospital & Healthcare Compensation Services' Nursing Home Salary & Benefits Report, for example, McKnight's Long Term Care News noted that "in 2022 alone, wages for certified nurse aides grew by 11.15%, with registered nurses just behind at 11.08% and licensed practical nurses netting about 9.38% more over the previous year."[1]

- Third, OSHA's methodology arrived at significantly different estimates for the total annualized cost per establishment across different aging services congregate living environments: $10,332 for nursing facilities; $6,498 for continuing care retirement facilities; and $1,861 for assisted living facilities. See Table 32 in the Preliminary Interim Regulatory Flexibility Analysis. We believe further analysis of these estimates is needed. For example, the estimates may not account adequately for baseline costs that any of these provider types would experience in order to comply with the proposed framework.

C. Section Specific Comments

To supplement our general comments above, we offer the following feedback about specific aspects of the proposed elements of the contemplated WPV framework.

29 CFR 1910.1031(a): Scope and Application

- If OSHA proceeds to rulemaking, it will be important to clarify the definition of residential care facilities as it relates to continuing care retirement communities, also referred to as life plan communities. While these settings offer assisted living and/or nursing facility levels of care, a fundamental aspect of these settings is the provision of housing and related amenities for independently living adults, and it would be important for the definition to clarify that the proposed requirements would not necessarily apply to all areas within these settings.

- OSHA includes "social assistance" in the scope of coverage, but the draft regulatory language does not define this term. While the background materials refer to NAICS codes that provide examples of the types of service providers that would be included, we believe this needs additional detail and clarification.

1910.1031(b): Definitions

- OSHA's contemplated definition of "high-risk service areas" appears too broad, when it states that any "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." When taken together with the

[1] See https://www.mcknights.com/print-news/is-pay-pain-reaching-its-peak-after-another-year-of-impressive-wage-growth/#:~:text=In%20a%20companion%20report%20issued,increase%20of%202.67%25%20in%202021.

proposed definition of a "workplace violence incident," it is likely that all or nearly all areas of a given facility will be classified as high-risk. This will be important, given that additional requirements would be triggered when a high-risk area exists, such as measures designed to control risk and training expectations.

- The framework defines "workplace violence incident" to mean "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." We believe the definition of this term would need further refinement if OSHA proceeded to rulemaking, given its centrality within the proposed framework. As many participants in the SBAR Panel process commented, it would be essential to have clarity about what constitutes a "violent act" for purposes of recording and investigating, as well further consideration of how to discern when a statement made by a person receiving services presents a threat in situations where the statement may be a manifestation of the individual's clinical condition.

- The term "workplace violence response teams" is defined but is not used elsewhere in the draft regulatory language, so potentially could be deleted. If the definition remained in a proposed standard, we note that it appears to establish a substantive requirement, namely that employees on such teams "do not have other assignments that would prevent them from responding immediately to an alarm to assist other staff." If this definition is intended to require employers to designate individuals whose sole responsibility is to be on call within an establishment for WPV response, it would raise feasibility concerns in light of staff capacity.

- On a related note, contemplated section 1910.1031(e) (Controls) requires standard operating procedures for staff designated to respond to workplace violence incidents. We believe further definition would be needed with regard to what staff would be required to designated, whether any specific credentials or training would be required in order to equip them to respond, and so on. We believe OSHA intends to afford flexibility on this issue and that would be important to clarify.

1910.1031(d): Workplace violence hazard assessment

- This section would require all employers to do the following as part of its initial and annual hazard assessments: (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.

  We are concerned about the burden and practicality of this requirement to compile and review retroactively all events falling within the proposed definition of workplace violence incidents. For example, it may require a review of the clinical records of all individuals served in order to compile the information, depending on the applicable definition. Further, we believe that what would be most useful and of most practical value would be data concerning events that have occurred recently enough for current staff to reflect on their implications.

If OSHA proceeded to rulemaking, we would support OSHA's suggested Hazard Assessment Alternative #1, under which employers would consider one year or two years of incident data, rather than three years of data. We believe a shorter period would sufficiently inform an employer's evaluation of what risk mitigation strategies are appropriate, especially in the context of conducting the succeeding, annual assessments for the purpose of informing any needed updates to an employer's established WPV program.

- In its background materials, OSHA notes: "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."

  We support the approach of providing employers with flexibility to tailor an assessment to its specific organizational context. In reading the contemplated hazard assessment requirements, however, we believe they may be more specific and prescriptive than necessary, especially when read in conjunction with the controls section.

  For example, OSHA would require all employers to assess all high-risk areas for specific issues, such as: (i) lack of physical barrier protection between employees and patients/visitors in areas such as admission, triage, and nursing stations; and (ii) presence of unsecured furnishings or other objects that could be used as weapons. Given the wording used here by OSHA, one might read this section to mean that steps must be taken to address each of these items – such as to establish physical barrier protections if they are lacking, or to secure furnishings if they are unsecured. We noted above the importance of a homelike setting and a person-centered model of care in residential aging services settings, and we believe that actions as these would not align with this model of care in many instances.

  If OSHA proceeds to rulemaking, we recommend that the agency take more general and flexible approach with respect to assessments, noting that the general purpose of the assessment is to 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.

1910.1031(e): Control Measures

- Returning briefly to definitions, we note that the contemplated regulatory language defines only "engineering controls" and "work practice controls." We believe any regulatory standard should also acknowledge that an employer might also utilize administrative controls, and a definition should be added to reflect that and for consistency.

- OSHA notes in background materials its understanding 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. We appreciate OSHA's

recognition and acknowledgment of this and support development of a distinct approach to assessment and control of risks if OSHA proceeds to rulemaking.

- We note that this section specifies certain control measures that all employers must implement, regardless of the results of the organization's hazard assessment, and we believe additional flexibility would be important for organizations to establish controls that are both effective from a protective standpoint but also feasible and appropriate to their settings of care.

  Subsection (e)(1)(i), for example, requires all employers to 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. As this is worded, and as the term "alarm" is defined, might we expect that hard-wired systems or advanced technological systems would be required to be installed? We also note, from a technical drafting standpoint, that the same requirement is duplicated in (e)(3)(i).

  Subsection (e)(4) offers another example, which requires all employers to provide appropriate personal protective equipment (PPE) such as bite resistant sleeves or protective face wear to employees. This requirement may be appropriate for some settings of care and some patient/client/resident populations, but it is not clear that is should apply to all employers.

- As written, this section also appears to require all covered employers to implement specific control measures in all high-risk areas, including some that would not be appropriate for an aging-services setting or model of care. We offer these examples to illustrate:

  - 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. The living spaces in which the individuals our members serve are their homes, and securing their personal belongings in this way would not be appropriate within their models of care, nor would it allow proper cleaning to occur.

  - Install protective barriers between employees and patients/visitors in areas such as admission, triage, and nursing stations. Barriers between employees and patients/visitors may disrupt vital communication and interactions with residents/clients and families that is common and important within our model of care.

  If OSHA proceeds, we recommend modifying the language to allow more flexibility to covered employers and support additional consideration of Control Measures Alternative #1a (require implementation of administrative/work practice controls but do not require engineering controls) or Control Measures Alternative #1b (require that employers implement a limited set of environmental or engineering controls).

- In sub-section (e)(3)(iv) OSHA states that "work practice" controls to address the risk of workplace violence must include "[e]nsuring 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.)."

This is an important example of an issue where OSHA's standard would duplicate requirements that aging services providers already are subject to through their licensing and certification requirements. We respectfully suggest that an OSHA standard addressing staffing adequacy would generate significant confusion, and likely conflicting expectations, and is more appropriately addressed through state and federal requirements already established. Further, evaluation of these issues must account for the fact that many aging services are facing workforce shortages, despite making every effort to hire and retain qualified staff.

- Sub-section (e)(1)(iv) would require all employers to "establish and implement policies and procedures for effective communication of a patient/client/resident's history or potential for violence to all subsequent external healthcare employers that a patient may be referred to."

  We recommend that OSHA further examine this potential requirement. An individual may transition out of an aging services setting or service for a variety of reasons. Sometimes the individual has completed a course of treatment, and no further referral is needed. Other times, such as transitioning from a skilled nursing facility stay to home, there may be a service referral, but only to one specific external entity. Depending on the situation, providers compile discharge recommendations with summaries of relevant information, following applicable licensing or certification requirements, as well as their own best practices.

  As written, however, this standard appears to contemplate a "flag" that would be embedded in an individual's health record and follow that person through all future healthcare interactions. If that were the intent, this raises questions, as noted by the SBAR panel participants, relating to data privacy, the relevance of a given event to all future care, and the potential to stigmatize individuals whose clinical conditions may have caused a specific incident to occur. We understand the value of ensuring successful transitions of care but urge OSHA to consider these complexities.

1910.1031(f): Training

- We appreciate that OSHA's proposed framework recognizes that different staff may require different training depending on their roles within the organization. This flexibility is important for organizations to tailor the education that is most needed by their staff, especially when accounting for training already being conducted in relation to patient care. We encourage OSHA to maintain or increase flexibility in this area.

- Subsection (f)(2) would require the training program to be overseen or conducted by a person knowledgeable in the program's subject matter as it relates to the workplace. We believe further definition would be needed to clarify what specific knowledge would be required or

this individual, and whether any specific certification or training would be required in order to fulfill the role. We believe OSHA intends to afford flexibility on this issue and that would be important to clarify.

- Relating to cost estimates for training, we encourage OSHA to consider that, given the breadth of the definition of "high risk area," employers would likely need to provide the additional training required in subsection (f)(5) to greater number of staff that OSHA has initially contemplated. We also recommend that OSHA take into account the relatively high rate of staff turnover that occurs in aging services, which may increase the cost estimates as well.

1910.1031(g): Violent incident investigation and recordkeeping.

- This section requires that employers establish procedures to investigate the circumstances surrounding each workplace violence incident, with such investigations to begin within 24 hours, and the section goes on to add substantial detail about what the process must entail.

  We understand the importance of investigation and the role that root cause analysis plays in understanding and preventing adverse events, however we are concerned about the compliance burden that this provision could create, especially given the broad definition of a "workplace violence incident".

  For some recipients of aging services, whether a home care client or an assisted living or nursing home resident, verbal aggression toward staff may unfortunately be a regular occurrence, as a manifestation of their clinical condition, for example. If all such resident communications toward staff constituted workplace violence incidents, this provision would create a level of repetitive investigatory activity that overwhelms existing staff capacity, and that may be of low practical value with respect to a client or resident whose needs are already understood and addressed in an on-going care plan to which staff are oriented and trained.

Conclusion

We appreciated the opportunity to monitor the SBAR panel proceedings and the opportunity to share these comments. For the reasons articulated above, we believe the framework should be modified if OSHA advances to a proposed rule. As the SBAR Panel process showed, these are complicated issues, and we urge OSHA to give careful consideration and undertake additional study through informal stakeholder engagement as it moves forward. We would be pleased to participate in such engagement to provide further perspective on these issues. Thank you for your consideration, and please contact me (jlips@leadingage.org) if we can answer any questions or provide additional information.

Sincerely,

Jonathan Lips
Vice President, Legal Affairs