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[1] https://www.osha.gov/sites/default/files/publications/osha3148.pdf

[2] https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/wpvp-r3-30_revised_06302021.pdf

[3] https://www.aha.org/system/files/media/file/2022/03/aha-urges-doj-to-protect-health-care-workers%E2%80%AF%E2%80%AFfrom-workplace-violence-letter-3-24-22.pdf

[4] https://www.congress.gov/congressional-report/117th-congress/house-report/14

1

APPROVED
MAY 3, 2022
BY GOVERNOR

CHAPTER
173
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-TWO

H.P. 465 - L.D. 629

Resolve, To Establish the Task Force To Study the Process for Bringing Criminal Cases in Situations of Violence against Health Care Workers

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the issue of violence against hospital and medical staff has increased in recent years; and

Whereas, hospitals are unclear what the options are for prosecution when victims are unwilling to bring cases; and

Whereas, the work of the Task Force To Study the Process for Bringing Criminal Cases in Situations of Violence against Health Care Workers needs to begin prior to 90 days after adjournment in order for the task force to have enough time to review the circumstances and make recommendations; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Task force established. Resolved: That the Task Force To Study the Process for Bringing Criminal Cases in Situations of Violence against Health Care Workers, referred to in this resolve as "the task force," is established.

Sec. 2. Task force membership. Resolved: That, notwithstanding Joint Rule 353, the task force consists of 9 members appointed as follows:

1. Two members of the Senate appointed by the President of the Senate, including members from each of the 2 parties holding the largest number of seats in the Legislature;

2. Two members of the House of Representatives appointed by the Speaker of the House, including members from each of the 2 parties holding the largest number of seats in the Legislature;

3. Two members who are representatives of entities knowledgeable about or involved in providing hospital, medical or mental health services, appointed by the President of the Senate;

4. Two members who are representatives of entities knowledgeable about or involved in providing hospital, medical or mental health services, appointed by the Speaker of the House; and

5. One member representing law enforcement officers, appointed by the Speaker of the House.

The task force shall also invite 2 members of the judicial branch and 2 members representing district attorneys designated by the Chief Justice of the Supreme Judicial Court to serve as members of the task force.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the task force.

Sec. 4. Appointments; convening of task force. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the task force. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the task force to meet and conduct its business.

Sec. 5. Duties. Resolved: That the task force shall review the process by which criminal cases may be brought related to incidents of violence in hospitals and other health care facilities and settings, in particular, incidents of violence involving patients or individuals related to patients assaulting hospital or medical staff.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the task force, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Report. Resolved: That, no later than November 2, 2022, the task force shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Criminal Justice and Public Safety. The joint standing committee is authorized to report out legislation to the First Regular Session of the 131st Legislature.

Sec. 8. Outside funding. Resolved: That the task force shall seek funding contributions to fully fund the costs of the study. All funding is subject to approval by the Legislative Council in accordance with its policies. If sufficient contributions to fund the study have not been received within 30 days after the effective date of this resolve, no meetings are authorized and no expenses of any kind may be incurred or reimbursed.

Sec. 9. Appropriations and allocations. Resolved: That the following appropriations and allocations are made.

LEGISLATURE

Study Commissions - Funding 0444

Initiative: Allocates funds from outside sources for the costs to the Legislature of the Task Force To Study the Process for Bringing Criminal Cases in Situations of Violence against Health Care Workers.

OTHER SPECIAL REVENUE FUNDS	**2021-22**	**2022-23**
Personal Services	$440	$440
All Other	$560	$810
OTHER SPECIAL REVENUE FUNDS TOTAL	$1,000	$1,250

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

2

§1704. Maximum fine amounts authorized for convicted individuals

An individual who has been convicted of a Class A, Class B, Class C, Class D or Class E crime may be sentenced to pay a fine. Except as provided in section 1706 and unless a different maximum fine is specified by statute, the maximum fine that may be imposed by a court on a convicted individual is as follows: [PL 2019, c. 113, Pt. A, §2 (NEW).]

1. Class A crime. In the case of a Class A crime, $50,000;
[PL 2019, c. 113, Pt. A, §2 (NEW).]

2. Class B crime. In the case of a Class B crime, $20,000;
[PL 2019, c. 113, Pt. A, §2 (NEW).]

3. Class C crime. In the case of a Class C crime, $5,000;
[PL 2019, c. 113, Pt. A, §2 (NEW).]

4. Class D crime. In the case of a Class D crime, $2,000; and
[PL 2019, c. 113, Pt. A, §2 (NEW).]

5. Class E crime. In the case of a Class E crime, $1,000.
[PL 2019, c. 113, Pt. A, §2 (NEW).]

SECTION HISTORY

PL 2019, c. 113, Pt. A, §2 (NEW).

3

§207. Assault

1. A person is guilty of assault if:

A. The person intentionally, knowingly or recklessly causes bodily injury or offensive physical contact to another person. Violation of this paragraph is a Class D crime; or [PL 2001, c. 383, §10 (NEW); PL 2001, c. 383, §156 (AFF).]

B. The person has attained at least 18 years of age and intentionally, knowingly or recklessly causes bodily injury to another person who is less than 6 years of age. Violation of this paragraph is a Class C crime. [PL 2001, c. 383, §10 (NEW); PL 2001, c. 383, §156 (AFF).]

[PL 2001, c. 383, §10 (RPR); PL 2001, c. 383, §156 (AFF).]

2.

[PL 2001, c. 383, §10 (RP); PL 2001, c. 383, §156 (AFF).]

3. For a violation under subsection 1, the court shall impose a sentencing alternative that involves a fine of not less than $300, which may not be suspended except as provided in subsection 4. [PL 2019, c. 113, Pt. B, §10 (AMD).]

4. Finding by court necessary to impose other than minimum fine. In the case of an individual, the court may suspend all or a portion of a minimum fine under subsection 3 or impose a lesser fine other than the mandatory fine if the court finds by a preponderance of the evidence that there are exceptional circumstances that justify imposition of a lesser financial penalty. In making a finding of exceptional circumstances, the court may consider:

A. Reliable evidence of financial hardship on the part of the individual and the individual's family and dependents; [PL 2019, c. 113, Pt. B, §11 (NEW).]

B. Reliable evidence of special needs of the individual or the individual's family and dependents; [PL 2019, c. 113, Pt. B, §11 (NEW).]

C. Reliable evidence of the individual's income and future earning capacity and the individual's assets and financial resources from whatever source; [PL 2019, c. 113, Pt. B, §11 (NEW).]

D. Reliable evidence regarding any pecuniary gain derived from the commission of the offense; and [PL 2019, c. 113, Pt. B, §11 (NEW).]

E. The impact of imposition of the mandatory fine on the individual's reasonable ability to pay restitution under chapter 69. [PL 2019, c. 113, Pt. B, §11 (NEW).]

[PL 2019, c. 113, Pt. B, §11 (NEW).]

SECTION HISTORY

PL 1975, c. 499, §1 (NEW). PL 1985, c. 495, §4 (AMD). PL 2001, c. 383, §10 (RPR). PL 2001, c. 383, §156 (AFF). PL 2005, c. 12, §JJ1 (AMD). PL 2019, c. 113, Pt. B, §§10, 11 (AMD).

4

§209. Criminal threatening

1. A person is guilty of criminal threatening if he intentionally or knowingly places another person in fear of imminent bodily injury.
[PL 1975, c. 499, §1 (NEW).]

2. Criminal threatening is a Class D crime.
[PL 1975, c. 499, §1 (NEW).]

SECTION HISTORY

PL 1975, c. 499, §1 (NEW).

5

§752-C. Assault on an emergency medical care provider

1. A person is guilty of assault on an emergency medical care provider if that person intentionally, knowingly or recklessly causes bodily injury to an emergency medical care provider while the emergency medical care provider is providing emergency medical care.
[PL 1997, c. 470, §1 (NEW).]

2. As used in this section, "emergency medical care provider" includes hospital personnel assisting in an emergency and emergency medical services persons, defined in Title 32, section 83, subsection 12, but does not include a firefighter as defined in section 752-E, subsection 2.
[PL 2015, c. 471, §1 (AMD).]

3. Assault on an emergency medical care provider is a Class C crime.
[PL 1997, c. 470, §1 (NEW).]

SECTION HISTORY

PL 1997, c. 470, §1 (NEW). PL 2015, c. 471, §1 (AMD).

6

129th MAINE LEGISLATURE

FIRST REGULAR SESSION-2019

Legislative Document	**No. 1199**
S.P. 374	In Senate, March 12, 2019

An Act To Protect the Safety of Health Care Workers

Reference to the Committee on Criminal Justice and Public Safety suggested and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator DOW of Lincoln.
Cosponsored by Senators: CLAXTON of Androscoggin, LIBBY of Androscoggin,
Representatives: COREY of Windham, MARTIN of Eagle Lake, RISEMAN of Harrison.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 17-A MRSA §752-C, as amended by PL 2015, c. 471, §1, is repealed and the following enacted in its place:

§752-C. Assault on a health care practitioner or hospital employee or contractor

1. A person is guilty of assault on a health care practitioner or hospital employee or contractor if that person intentionally, knowingly or recklessly causes bodily injury to a health care practitioner while that health care practitioner is providing medical care or to a hospital employee or person working for a hospital on a contractual basis while that employee or person is performing duties related to the provision of care for a patient or a prospective patient.

2. As used in this section, unless the context otherwise indicates "health care practitioner" means a physician or other person certified, registered or licensed in the healing arts, including, but not limited to, a nurse, podiatrist, optometrist, chiropractor, physical therapist, dentist, psychologist, physicians' assistant or emergency medical services' person, as defined in Title 32, section 83, subsection 12. "Heath care practitioner" includes hospital personnel assisting in providing medical care but does not include a firefighter as defined in section 752-E, subsection 2.

3. Assault on a health care practitioner or hospital employee or contractor is a Class C crime.

SUMMARY

This bill provides that an assault on a health care practitioner while that health care practitioner is providing medical care or an assault on a hospital employee or person working for a hospital on a contractual basis while that employee or person is performing duties related to the provision of care for a patient or a prospective patient is a Class C crime.

129th Maine Legislature, First Regular Session

An Act To Protect the Safety of Health Care Workers

LD 1199, SP 374

Fiscal Status Not Yet Determined

Final Disposition Ought Not to Pass Pursuant To Joint Rule 310, Apr 25, 2019

Amendments to LD 1199

Status In Committee

Referred to Committee on Criminal Justice and Public Safety **on** Mar 12, 2019.

Latest Committee Action: Reported Out, Apr 22, 2019, ONTP

Latest Committee Report: Apr 22, 2019; Ought Not To Pass

Public Hearings

Wednesday, April 3, 2019 1:00 PM, State House, Room 436

Disclaimer: The following documents are digital reproductions of written testimony presented to joint standing committees before and during public hearings. The Legislature is not responsible for the content, accuracy, or appropriateness of any testimony posted herein and takes no position supporting or opposing views expressed in the testimony. The documents are posted solely for convenient viewing by interested persons; they are not official copies and may not represent a complete record of a hearing. Contact the committee clerk for additional information.

☐ Public Hearing Testimony

Austin, Jeffrey	*Maine Hospital Association*	(102 KB)
Baumann, Michael	*Maine Health*	(118 KB)
Davis, Dan	*Porter*	(68 KB)
Dow, Dana	*Maine State Legislature*	(75 KB)
McKee, Walter	*Maine Association of Criminal Defense Lawyers*	(63 KB)
Mehnert, Jenna	*National Alliance on Mental Illness*	(89 KB)
Michaud, Peter	*Maine Medical Association*	(76 KB)
Shaughnessy, Malory	*Alliance for Addiction and Mental Health Services, Maine*	(73 KB)
Sway, Meagan	*American Civil Liberties Union of Maine*	(104 KB)

Work Sessions

Friday, April 12, 2019 1:00 PM, State House, Room 436

Committee Docket

Date	Action	Result
Apr 12, 2019	Work Session Held	
Apr 12, 2019	Voted	ONTP
Apr 22, 2019	Reported Out	ONTP

Divided Reports

No Divided Reports.

Affected Statute Titles and Sections

Title	Section	Subsection	Paragraph	Effect	Law Type	Chapter
17-A	752-C			RPR		null
17-A	752-C			RPR		null

Need a paper copy? Contact the Document Room at 287-1408 or send an e-mail with the LD or Paper number, Item number and a mailing address to webmaster_house@legislature.maine.gov.

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7

§1832. Safety and security in hospitals

A hospital licensed under this chapter shall, on an annual basis, adopt a safety and security plan to protect the patients, visitors and employees of the hospital from aggressive and violent behavior. The safety and security plan must include a process for hospitals to receive and record incidents and threats of violent behavior occurring at or arising out of employment at the hospital. The safety and security plan must prohibit a representative or employee of the hospital from interfering with a person making a report as provided in the plan. [PL 2011, c. 254, §1 (NEW); PL 2011, c. 254, §2 (AFF).]

SECTION HISTORY

PL 2011, c. 254, §1 (NEW). PL 2011, c. 254, §2 (AFF).

8

125th MAINE LEGISLATURE

FIRST REGULAR SESSION-2011

Legislative Document **No. 472**

H.P. 365 House of Representatives, February 10, 2011

An Act To Enhance the Security of Hospital Patients, Visitors and Employees

Reference to the Committee on Health and Human Services suggested and ordered printed.

HEATHER J.R. PRIEST
Clerk

Presented by Representative CELLI of Brewer.
Cosponsored by Representative: RIOUX of Winterport.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1832 is enacted to read:

§1832. Safety and security in hospitals

1. Safety and security plan. By January 1, 2012 and annually thereafter, a hospital shall adopt a safety and security plan to protect the patients, visitors and employees of the hospital from aggressive and violent behavior. A hospital safety and security plan must comply with the provisions of this subsection.

A. In developing a safety and security plan, a hospital shall consider guidelines and standards on violence in health care facilities issued by the department, the Department of Labor and the federal Department of Labor, Occupational Safety and Health Administration.

B. In developing a safety and security plan, a hospital shall consult with affected employees, including but not limited to any recognized collective bargaining agent. A hospital may consult with its affected employees.

C. A safety and security plan must provide for adequate employee training to prevent and respond to violent acts.

D. A safety and security plan must include the following security considerations:

(1) The physical layout of the hospital;

(2) Staffing and staffing patterns and patient classification systems and an analysis of their contribution and connection to aggressive and violent behavior;

(3) The adequacy of the hospital's security systems, protocols and policies, including the availability of security personnel;

(4) The potential security risks associated with specific units or areas of the hospital where there is a greater likelihood that a patient, visitor or other person may exhibit aggressive or violent behavior;

(5) Public access to the hospital;

(6) Potential security risks associated with working late night or early morning hours;

(7) The potential use of a trained response team to assist an employee during an incident of aggressive or violent behavior;

(8) Employee security in areas surrounding the hospital, including employee parking areas;

(9) Policies and training related to appropriate response to aggressive and violent behavior; and

(10) Efforts to cooperate with law enforcement regarding aggressive and violent behavior in the hospital.

E. A safety and security plan must include the following:

(1) Personnel training policies to protect patients, visitors and employees, including education on recognizing the potential for violence, when and how to seek assistance, how to report an incident of aggressive or violent behavior and how to file criminal charges. For employees regularly assigned to an emergency department or psychiatric unit, the policies must require annual training related to:

(a) General and personal safety measures;

(b) Factors that predict aggression and violence;

(c) Obtaining the patient history of a patient who has a history at the hospital of violent behavior;

(d) Characteristics of aggressive and violent patients and of victims;

(e) Verbal and physical maneuvers to defuse potentially violent situations and avoid violent behavior;

(f) Strategies to avoid physical harm;

(g) Restraining techniques, including the appropriate use of chemical restraints; and

(h) Any resources available to employees for coping with incidents of violence, including but not limited to critical incident stress management, debriefing and employee assistance programs;

(2) A system for responding to immediate threats and incidents of aggressive or violent behavior, including immediate assistance if needed;

(3) A system for investigating threats or incidents of aggressive and violent behavior that must include interviewing any person who was threatened with or was the subject of aggressive or violent behavior;

(4) A system for reporting to the hospital, recording and monitoring situations of risk, threats and incidents of aggressive and violent behavior;

(5) A system for reporting to the Department of Public Safety, Bureau of State Police incidents of aggressive and violent behavior. The system must require reporting all criminal threatening or assaults committed by a patient or a person accompanying a patient, with recording of the date, time and location of the incident, the name of the person who committed the criminal threatening or assault and the person who was the victim of the criminal threatening or assault, a description of the incident and the response of the hospital. The system must require reporting within 24 hours all assaults that result in injury and all criminal threatening and all assaults that involve the use of a firearm or other dangerous weapon or that present an urgent or emergent threat to the health, safety or welfare of patients, visitors or employees. The system must require reporting all other reportable incidents within 72 hours; and

(6) Modifications in job design, staffing, security, equipment or facilities to prevent or address aggressive and violent behavior against patients, visitors or employees.

F. A safety and security plan must provide for:

(1) An appropriate response by the hospital that protects the alleged perpetrator and the alleged victim;

(2) The right of an employee to seek assistance and intervention from law enforcement and evaluation and treatment for physical or emotional injuries without retaliation by the hospital; and

(3) Evaluation and treatment for an employee who is a victim of an incident of violence, including, if requested by the employee, access to individual crisis counseling, support group counseling, peer assistance and professional referrals to address trauma or distress.

G. A safety and security plan must include a system for tracking incidents of aggressive and violent behavior and the hospital's responses to those incidents as part of the hospital's quality assessment and improvement program.

2. Security staffing. A hospital shall provide security staffing to meet the requirements of a safety and security plan under subsection 1 and shall provide training to security staff on the role of security, the identification of factors that predict violence and aggression and management of critical incidents.

3. Immunity. A hospital or employee of a hospital who in good faith makes a report to the Department of Public Safety pursuant to a safety and security plan under subsection 1 is immune from liability for making the report.

4. Interference prohibited. A person may not interfere with or obstruct reporting pursuant to a safety and security plan under subsection 1. A person who violates this subsection commits a Class E crime.

5. Penalties. The department may impose an administrative penalty against a hospital or a licensee of a hospital for a violation of the reporting requirements of a safety and security plan adopted pursuant to subsection 1 in an amount not exceeding $7,500 for a first violation, $10,000 for a 2nd violation and $12,500 for a 3rd or subsequent violation.

6. Department of Public Safety response. When the Department of Public Safety receives a report that indicates an ongoing, urgent or emergent threat of imminent danger of death or serious injury to the patients, visitors or employees of a hospital, the Department of Public Safety shall visit the hospital to inspect or investigate the threat within 2 business days of receiving the report and shall complete any investigation and report to the Department of Health and Human Services within 45 days.

Sec. 2. 34-A MRSA §1803, sub-§3, ¶A-1 is enacted to read:

A-1. Adopt standards for safety and security plans in correctional facilities and county jails to protect inmates and employees from aggression and violence;

Sec. 3. Report. The Department of Health and Human Services shall report to the Legislature by January 31st each year, beginning in 2013, regarding reports on incidents of violence in hospitals made to the department for the previous year pursuant to hospital

safety and security plans required under the Maine Revised Statutes, Title 22, section 1832. The report must protect patient and employee confidentiality, must provide the total number of reports, must identify the hospital facilities and any inspections or investigations, must provide information on any administrative penalties levied by the department for violations and may include recommendations on how to prevent incidents of violence in hospitals.

SUMMARY

This bill requires the adoption of safety and security plans to protect patients, visitors and employees in hospitals. The plan would require training for employees, a system for reporting, investigation of incidents of violence, a guarantee of the employee's right to seek assistance and treatment, immunity for good faith reporting of incidents and reporting to the Department of Public Safety and from that department to the Department of Health and Human Services. It requires the State Board of Corrections to adopt standards for safety and security plans in correctional facilities and county jails. It also requires annual reporting from the Department of Health and Human Services to the Legislature on reports of violence in hospitals.

129th Maine Legislature, First Regular Session

An Act To Protect the Safety of Health Care Workers

LD 1199, SP 374

Fiscal Status Not Yet Determined

Final Disposition Ought Not to Pass Pursuant To Joint Rule 310, Apr 25, 2019

Amendments to LD 1199

Status In Committee

Referred to Committee on Criminal Justice and Public Safety **on** Mar 12, 2019.

Latest Committee Action: Reported Out, Apr 22, 2019, ONTP

Latest Committee Report: Apr 22, 2019; Ought Not To Pass

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Wednesday, April 3, 2019 1:00 PM, State House, Room 436

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Apr 12, 2019	Voted	ONTP
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Divided Reports

No Divided Reports.

Affected Statute Titles and Sections

Title	Section	Subsection	Paragraph	Effect	Law Type	Chapter
17-A	752-C			RPR		null
17-A	752-C			RPR		null

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9

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

Enhanced Penalties for Assault on Specified Personnel

Created October 2016 (Updated December 2017)

State	Citation	Personnel That Qualify For Enhanced Penalties
Alabama	§13A-6-21; §13A-6-22	Includes peace officers, detention or correctional officers, emergency medical personnel, utility workers, firefighters, teacher or employees of a public educational institution, and health care workers.
Alaska		None located.
Arizona	§13-1204	Aggravated penalties for assault of peace officers, constables, firefighters, emergency personal, teachers or school employees, health care workers, prosecutors, code enforcement officers, state or municipal park rangers, public defenders, and judicial officers.
Arkansas	§5-13-202	Battery only. Includes law enforcement officers, firefighters, code enforcement officers, employees of a correctional facility, teachers, school employees, employees of the state, and medical personnel.
California	Penal Code §241	Includes peace officers, parking control officers, emergency personal, firefighters, lifeguards, process servers, traffic officers, code enforcement officers, animal control officers, search and rescue members, and health care providers.
Colorado	§18-3-202; §18-3-203	Includes peace officers, fire fighters, emergency medical personnel, judges and officers of the court, correctional facility employees, employees of the Department of Human Services who work with youth.
Connecticut	§53a-167c	Includes peace officers, public safety personnel, emergency medical personnel, firefighters, department of corrections employees, members/employees of the board of pardons and parole, probation officers, employee of the Department of Children and Families, employees of the Judicial Branch, emergency room physicians and nurses, public transit employees, motor vehicle employees, liquor control agents, members of a canine search and rescue team.
Delaware	11 Del. C. §612	Includes peace officers, fire and emergency personnel, security officers, state employees, correctional officers, public transit operators, medical professionals, and code enforcement constables.
Florida	§784.074; §784.075; §784.076; §784.078; §784.081; §784.083	Includes law enforcement officers, fire fighters, emergency medical care providers, public transportation employees, parking enforcement officers, security officers, railroad special officers, health services providers, code inspectors, sexually violent predator detention staff and faculty, sports officials, school employees, elected officials, university employees, Department of Children and Families employees, Department of Health employees, and correctional facility officers. Battery includes juvenile probation officers, persons employed by the Department of Juvenile Justice, persons employed at facilities licensed by the Department of Juvenile Justice, persons employed at facilities operated under a contract with the Department of Juvenile Justice, and health services personnel (preventive, diagnostic, curative, or rehabilitative services and includes alcohol treatment, drug abuse treatment, and mental health services).
Georgia	§16-5-21; §16-5-23; §16-5-24	Includes peace officers, detention officers, sports officials, public school employees, teachers, students, judicial officers, and correctional officers.
Hawaii	§707-712.5; §707-712.6; §707-712.7	Includes law enforcement officers and emergency workers.

State	Citation	Personnel That Qualify For Enhanced Penalties
Idaho	§18-915	Includes peace officers, former peace officers, judges, officers of the court, prosecutors, public defenders, correctional officers and employees of the department of corrections or contractors, probation and parole officers, social workers, emergency personnel, employees of the department of water resources, employees of state tax commission, employees of a state secure confinement facility for juveniles, employees of a juvenile detention facility, and teachers at a detention facility or a juvenile probation officer.
Illinois	720 ILCS 5/12-2; 720 ILCS 5/12-3.05	Includes teachers, school employees, park district employees, community policing volunteers, private security officers, utility workers, peace officers, firemen, emergency management workers, emergency medical services personnel, correction or probation officers, Department of Human Services employees, State of Illinois employees, transit employees, process servers, sports officials, and coaches.
Indiana	§35-42-2-1	Battery includes law enforcement officers, alcoholic beverage enforcement officers, penal facility employees, juvenile detention facility employees, department of corrections employees, probation officers, parole officers, community corrections workers, home detention officers, department of child services employees, firefighters, emergency medical services providers, and judicial officers.
Iowa	§708.3A	Includes peace officers, jailers, correctional staff, members or employees of the board of parole, health care providers, employees of the department of human services, employees of the department of revenue, and fire fighters (including volunteer).
Kansas	§21-5412; §21-5413	Assault includes law enforcement officers. Battery includes law enforcement officers, campus police officers, judges, attorneys, corrections officers, juvenile detention facility officers, school employees, and mental health employees.
Kentucky	§508.025	Includes peace officers, correctional facility employees, residential treatment facility employees, social workers, emergency medical services personnel, fire fighters (including volunteer), disaster or emergency services workers, probation officers, parole officers, transportation officers, detention facility employees, teachers, school employees, and school volunteers.
Louisiana	§14:34 et. seq.	Includes active military, disabled veterans, police officers, school teachers, sports officials, correctional facility employees, bus operators, emergency service personnel, health care professionals, child welfare or adult protective service workers, and utility workers.
Maine	17-A §752-A et seq.	Includes law enforcement, corrections officers, emergency medical care providers, and firefighters.
Maryland	Criminal Law §3-203	Includes law enforcement officers, parole or probation agents, firefighters, and other first responders providing medical care or rescue services.
Massachusetts	265 §13D; 265 §13D½ 265 §13I	Includes public employees, firefighters, health care providers, and emergency medical technicians.
Michigan	§750.81c; §750.81d; §750.81e	Includes employees of family independence agencies, fire fighters, emergency medical service providers, police officers, campus police, sheriffs, peace officers, conservation officers, constables, search and rescue personnel, and public utility workers.
Minnesota	§609-221; §609-2231	Includes peace officers, prosecuting attorneys, judges, correctional employees, fire fighters, emergency medical providers, secure treatment facility personnel, school officials, certain public employees with mandated duties, community crime prevention members, reserve officers, utility and postal service employees, transit operators, and Department of Natural Resources employees.

State	Citation	Personnel That Qualify For Enhanced Penalties
Mississippi	§97-3-7	Includes statewide elected officials, law enforcement officers, firemen, emergency medical personnel, public health personnel, social workers, family protection specialists or family protection workers employed by the Department of Human Services or another agency, Division of Youth Services personnel, any county or municipal jail officers, school employees, members of the Mississippi National Guard, military personnel, legislators, judges, officers of the court, prosecutors, public defenders, and utility workers.
Missouri	§565.002	Includes law enforcement officers, emergency personnel, emergency health care personnel, firefighters (including volunteer), probation officers, parole officers, corrections officers, highway workers, utility workers, cable workers, and mass transit employees.
Montana	§45-5-210; §45-5-211	Includes peace officers, judicial officers, and sports officials.
Nebraska	§28-929 et. seq.	Includes peace officers, emergency responders, state correctional employees, Department of Health and Human Services employees, and health care professionals.
Nevada	§200.471; §200.481	Includes peace officers, firefighters (including volunteers), correctional officers, judges or officers of the court, state employees who duties require they make home visits; health care providers; school employees, sports officials, taxi cab drivers, and public transit operators.
New Hampshire	§631:4-a	Enhances penalties for bodily injury or any crime (or threats of either) against the following people and their immediate families: Sitting members of the general court, executive councilors, past governors, present governor, members of the judiciary, and marital masters.
New Jersey	2C:12-1	Includes law enforcement, firefighters (including volunteer), persons engaged in emergency first-aid or medical services, school employees, school board members, Division of Child Protection and Permanency employees, judges, motorbus operators, rail passenger service employees, Department of Corrections employees, utility workers, and healthcare workers.
New Mexico	§ 30-3-9 et. seq.	Includes school employees, sports officials, and health care personnel.
New York	N.Y. Penal §120.08; §120.09; §120.11	Includes peace officers, police officers, probation officers, parole officers, members of the North Carolina National Guard, detention facility employees, emergency medical services personnel, hospital personnel, firefighters, and judges.
North Carolina	§14-34.6; §14-34.7	Includes emergency medical personnel, healthcare providers, firefighters, law enforcement officers, probation officers, parole officers and employees at correctional facilities, and members of the North Carolina National Guard.
North Dakota	§12.1-17-01	Includes peace officers, corrections employees, employees of a state hospitals, persons engaged in a judicial proceeding, firefighters (including volunteer), and emergency medical services personnel.
Ohio	§2903.13	Includes peace officers, employees of a correctional facility, school employees (teachers or administrators or school bus operators), firefighters, emergency medical services personnel, health care professionals, employees of a children services agency, employees of the department of rehabilitation services, judges, prosecutors, and other court employees.
Oklahoma	21 §649, §650 et. seq.	Includes police officers, peace officers, corrections personnel, sports officials, Department of Human Services personnel, Department of Juvenile Affairs personnel, emergency medical personnel, officers of the court, witnesses, jurors, and school employees.
Oregon	§163.208	Includes peace officers, corrections officers, parole and probation officers, animal control officers, and firefighters.

State	Citation	Personnel That Qualify For Enhanced Penalties
Pennsylvania	18 Pa.C.S.A §2702	Includes police officers, firefighters, probation and parole officers, agents of the parole board, sheriffs, liquor control enforcement agents, correctional officers, judges, the Attorney General, public defenders, district attorneys, all law enforcement officials, emergency medical services personnel, parking enforcement officers, constables, psychiatric aides, employees of a school, governors, lieutenant governors, auditor generals, state treasurers, members of the general assembly, employees of the Department of Environmental protection, private detectives, employees of a children and youth social service agency, public utility workers, wildlife conservation officers, and waterways conservation officers.
Rhode Island	§11-5-5	Includes police officers, probation and parole officers, state government caseworkers, judges, sheriffs, firefighter, public transit drivers, campus police, members of the Rhode Island fugitive task force, the attorney general investigators.
South Carolina		None located.
South Dakota	§22-18-1.05	Includes law enforcement officers, Department of Corrections employees or persons under contract assigned to the Department of Corrections.
Tennessee	§39-13-102	Includes any public employee or employees of a transportation system, law enforcement officers, firefighters, emergency medical personnel, health care providers, and other first responders.
Texas	Tex. Penal Code Ann. §22.01	Includes public servants, persons who contract with government to perform a service in a facility, security officers, emergency services personnel, and sports participants.
Utah	§76-5-102 et. seq.	Includes school employees, peace officers, military service members, health care providers, and emergency medical service employee.
Vermont	13 VSA §1024, §1028, §1028a	Includes law enforcement officers, firefighters, health care workers, employees of the Department for Children and Families, employees of the Department of Corrections, and emergency medical personnel.
Virginia	§18.2-57	Includes judges, law enforcement officers, correctional officers, firefighters, school employees, and emergency medical personnel.
Washington	§9A.36.031	Includes court staff, transit operators, school bus drivers, school district employees, firefighters, law enforcement, peace officers, and health care personnel.
West Virginia	§61-2-10b	Includes government representatives, health care providers, utility workers, emergency service personnel, correctional employees, and law-enforcement officers.
Wisconsin	§940.20	Includes firefighters, commission wardens, parole and probation officers, jurors, public officers, school employees, public transit officers, and emergency medical care providers.
Wyoming	§6-5-204	Includes peace officers and probation and parole officers.

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29 U.S.C.
United States Code, 2020 Edition
Title 29 - LABOR
CHAPTER 15 - OCCUPATIONAL SAFETY AND HEALTH
Sec. 654 - Duties of employers and employees
From the U.S. Government Publishing Office, www.gpo.gov

§654. Duties of employers and employees

(a) Each employer—

(1) 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;

(2) shall comply with occupational safety and health standards promulgated under this chapter.

(b) Each employee shall comply with occupational safety and health standards and all rules, regulations, and orders issued pursuant to this chapter which are applicable to his own actions and conduct.

(Pub. L. 91–596, §5, Dec. 29, 1970, 84 Stat. 1593.)

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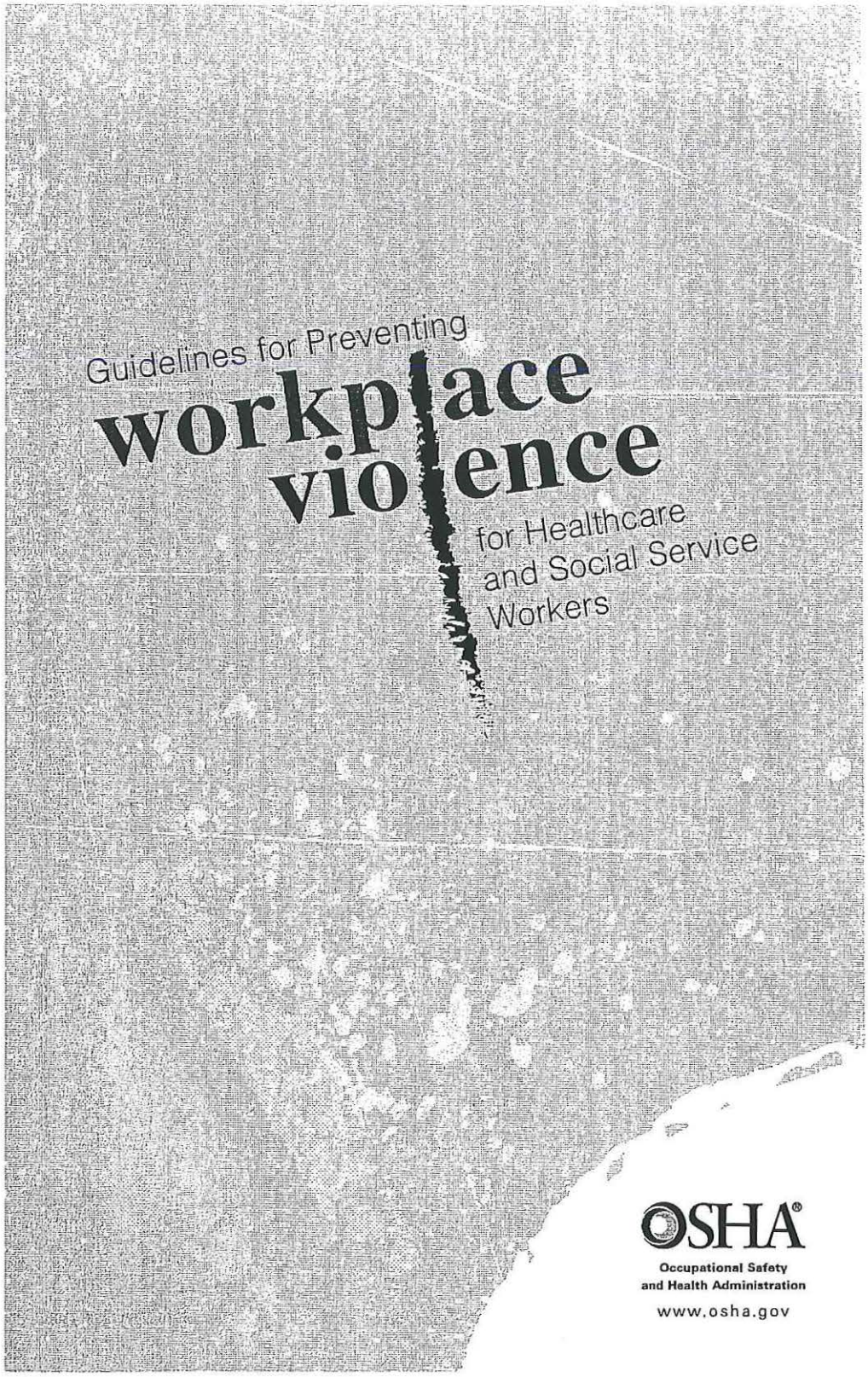
Guidelines for Preventing
workplace violence
for Healthcare and Social Service Workers
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Occupational Safety and Health Act of 1970
"To assure safe and healthful working conditions for working men and women; by authorizing enforcement of the standards developed under the Act; by assisting and encouraging the States in their efforts to assure safe and healthful working conditions; by providing for research, information, education, and training in the field of occupational safety and health..."

This publication provides a general overview of worker rights under the *Occupational Safety and Health Act* (OSH Act). This publication does not alter or determine compliance responsibilities which are set forth in OSHA standards and the OSH Act. Moreover, because interpretations and enforcement policy may change over time, for additional guidance on OSHA compliance requirements the reader should consult current administrative interpretations and decisions by the Occupational Safety and Health Review Commission and the courts.

This information will be made available to sensory-impaired individuals upon request. Voice phone: (202) 693-1999; teletypewriter (TTY) number: 1-877-889-5627.

Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers

U.S. Department of Labor
Occupational Safety and Health Administration

OSHA 3148-06R 2016

U.S. Department of Labor

This guidance document is advisory in nature and informational in content. It is not a standard or regulation, and it neither creates new legal obligations nor alters existing obligations created by the Occupational Safety and Health Administration (OSHA) standards or the *Occupational Safety and Health Act of 1970* (OSH Act or Act). Pursuant to the OSH Act, employers must comply with safety and health standards and regulations issued and enforced either by OSHA or by an OSHA-approved state plan. In addition, the Act's General Duty Clause, Section 5(a)(1), requires employers to provide their workers with a workplace free from recognized hazards that are causing or likely to cause death or serious physical harm. In addition, Section 11(c)(1) of the Act provides that "No person shall discharge or in any manner discriminate against any employee because such employee has filed any complaint or instituted or caused to be instituted any proceeding under or related to this Act or has testified or is about to testify in any such proceeding or because of the exercise by such employee on behalf of himself or others of any right afforded by this Act." Reprisal or discrimination against an employee for reporting an incident or injury related to workplace violence, related to this guidance, to an employer or OSHA would constitute a violation of Section 11(c) of the Act. In addition, 29 CFR 1904.36 provides that Section 11(c) of the Act prohibits discrimination against an employee for reporting a work-related fatality, injury or illness.

Table of Contents

Overview of the Guidelines

Healthcare and social service workers face significant risks of job-related violence and it is OSHA's mission to help employers address these serious hazards. This publication updates OSHA's 1996 and 2004 voluntary guidelines for preventing workplace violence for healthcare and social service workers. OSHA's violence prevention guidelines are based on industry best practices and feedback from stakeholders, and provide recommendations for developing policies and procedures to eliminate or reduce workplace violence in a range of healthcare and social service settings.

These guidelines reflect the variations that exist in different settings and incorporate the latest and most effective ways to reduce the risk of violence in the workplace. Workplace setting determines not only the types of hazards that exist, but also the measures that will be available and appropriate to reduce or eliminate workplace violence hazards.

For the purpose of these guidelines, we have identified five different settings:

- **Hospital** settings represent large institutional medical facilities;
- **Residential Treatment** settings include institutional facilities such as nursing homes, and other long-term care facilities;
- **Non-residential Treatment/Service** settings include small neighborhood clinics and mental health centers;
- **Community Care** settings include community-based residential facilities and group homes; and
- **Field work** settings include home healthcare workers or social workers who make home visits.

Indeed, these guidelines are intended to cover a broad spectrum of workers, including those in: psychiatric facilities, hospital emergency departments, community mental health clinics, drug abuse treatment centers, pharmacies, community-care centers, and long-term care facilities. Healthcare and social service workers covered by these guidelines include: registered nurses, nurses' aides, therapists, technicians, home healthcare workers,

social workers, emergency medical care personnel, physicians, pharmacists, physicians' assistants, nurse practitioners, and other support staff who come in contact with clients with known histories of violence. Employers should use these guidelines to develop appropriate workplace violence prevention programs, engaging workers to ensure their perspective is recognized and their needs are incorporated into the program.

Violence in the Workplace: The Impact of Workplace Violence on Healthcare and Social Service Workers

Healthcare and social service workers face a significant risk of job-related violence. The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty."[1] According to the Bureau of Labor Statistics (BLS), 27 out of the 100 fatalities in healthcare and social service settings that occurred in 2013 were due to assaults and violent acts.

While media attention tends to focus on reports of workplace homicides, the vast majority of workplace violence incidents result in non-fatal, yet serious injuries. Statistics based on the Bureau of Labor Statistics (BLS) and National Crime Victimization Survey (NCVS)[2] data both reveal that workplace violence is a threat to those in the healthcare and social service settings. BLS data show that the majority of injuries from assaults at work that required days away from work occurred in the healthcare and social services settings. Between 2011 and 2013, workplace assaults ranged from 23,540 and 25,630 annually, with 70 to 74% occurring in healthcare and social service settings. For healthcare workers, assaults comprise 10-11% of workplace injuries involving days away from work, as compared to 3% of injuries of all private sector employees.

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[1] CDC/NIOSH. Violence. Occupational Hazards in Hospitals. 2002.

[2] Cited in the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics report, Workplace Violence, 1993-2009 National Crime Victimization Survey and the Census of Fatal Occupational Injuries. March 2011. (www.bjs.gov/content/pub/pdf/wv09.pdf)

In 2013, a large number of the assaults involving days away from work occurred at healthcare and social assistance facilities (ranging from 13 to 36 per 10,000 workers). By comparison, the days away from work due to violence for the private sector as a whole in 2013 were only approximately 3 per 10,000 full-time workers. The workplace violence rates highlighted in BLS data are corroborated by the NCVS, which estimates that between 1993 and 2009 healthcare workers had a 20% (6.5 per 1,000) overall higher rate of workplace violence than all other workers (5.1 per 1,000).[3] In addition, workplace violence in the medical occupations represented 10.2% of all workplace violence incidents. It should also be noted that research has found that workplace violence is underreported—suggesting that the actual rates may be much higher.

Risk Factors: Identifying and Assessing Workplace Violence Hazards

Healthcare and social service workers face an increased risk of work-related assaults resulting primarily from violent behavior of their patients, clients and/or residents. While no specific diagnosis or type of patient predicts future violence, epidemiological studies consistently demonstrate that inpatient and acute psychiatric services, geriatric long term care settings,

[3] The report defined medical occupations as: physicians, nurses, technicians, and other medical professionals.

high volume urban emergency departments and residential and day social services present the highest risks. Pain, devastating prognoses, unfamiliar surroundings, mind and mood altering medications and drugs, and disease progression can also cause agitation and violent behaviors.

While the individual risk factors will vary, depending on the type and location of a healthcare or social service setting, as well as the type of organization, some of the risk factors include:

Patient, Client and Setting-Related Risk Factors

- Working directly with people who have a history of violence, abuse drugs or alcohol, gang members, and relatives of patients or clients;
- Transporting patients and clients;
- Working alone in a facility or in patients' homes;
- Poor environmental design of the workplace that may block employees' vision or interfere with their escape from a violent incident;
- Poorly lit corridors, rooms, parking lots and other areas;[4]
- Lack of means of emergency communication;
- Prevalence of firearms, knives and other weapons among patients and their families and friends; and
- Working in neighborhoods with high crime rates.

Organizational Risk Factors

- Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff;
- Working when understaffed—especially during mealtimes and visiting hours;
- High worker turnover;
- Inadequate security and mental health personnel on site;

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[4] CDC/NIOSH. Violence. Occupational Hazards in Hospitals. 2002.

- Long waits for patients or clients and overcrowded, uncomfortable waiting rooms;
- Unrestricted movement of the public in clinics and hospitals; and
- Perception that violence is tolerated and victims will not be able to report the incident to police and/or press charges.

Violence Prevention Programs

A written program for workplace violence prevention, incorporated into an organization's overall safety and health program, offers an effective approach to reduce or eliminate the risk of violence in the workplace. The building blocks for developing an effective workplace violence prevention program include:

(1) Management commitment and employee participation,

(2) Worksite analysis,

(3) Hazard prevention and control,

(4) Safety and health training, and

(5) Recordkeeping and program evaluation.

A violence prevention program focuses on developing processes and procedures appropriate for the workplace in question.

Specifically, a workplace's violence prevention program should have clear goals and objectives for preventing workplace violence, be suitable for the size and complexity of operations and be adaptable to specific situations and specific facilities or units. The components are interdependent and require regular reassessment and adjustment to respond to changes occurring within an organization, such as expanding a facility or changes in managers, clients, or procedures. And, as with any occupational safety and health program, it should be evaluated and reassessed on a regular basis. Those developing a workplace violence prevention program should also check for applicable state requirements. Several states have passed legislation and developed requirements that address workplace violence.

1. Management Commitment and Worker Participation

Management commitment and worker participation are essential elements of an effective violence prevention program. 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. Developing procedures to ensure that management and employees are involved in the creation and operation of a workplace violence prevention program can be achieved through regular meetings—possibly as a team or committee.[5]

Effective management leadership begins by recognizing that workplace violence is a safety and health hazard.

Effective management leadership begins by recognizing that workplace violence is a safety and health hazard. Management commitment, including the endorsement and visible involvement of top management, provides the motivation and resources for workers and employers to deal effectively with workplace violence. This commitment should include:

- Acknowledging the value of a safe and healthful, violence-free workplace and ensuring and exhibiting equal commitment to the safety and health of workers and patients/clients;
- Allocating appropriate authority and resources to all responsible parties. Resource needs often go beyond financial needs to include access to information, personnel, time, training, tools, or equipment;
- Assigning responsibility and authority for the various aspects of the workplace violence prevention program to ensure that all managers and supervisors understand their obligations;
- Maintaining a system of accountability for involved managers, supervisors and workers;
- Supporting and implementing appropriate recommendations from safety and health committees;

[5] If employers take this approach, they should consult and follow the applicable provisions of the *National Labor Relations Act*—29 U.S.C. 151-169.

- Establishing a comprehensive program of medical and psychological counseling and debriefing for workers who have experienced or witnessed assaults and other violent incidents and ensuring that trauma-informed care is available; and
- Establishing policies that ensure the reporting, recording, and monitoring of incidents and near misses and that no reprisals are made against anyone who does so in good faith.

Additionally, management should: (1) articulate a policy and establish goals; (2) allocate sufficient resources; and (3) uphold program performance expectations.

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. Mental health specialists have the ability to appropriately characterize disease characteristics but may need training and input from threat assessment professionals. Direct care workers, in emergency departments or mental health, may bring very different perspectives to committee work. The range of viewpoints and needs should be reflected in committee composition. This involvement should include:

- Participation in the development, implementation, evaluation, and modification of the workplace violence prevention program;
- Participation in safety and health committees that receive reports of violent incidents or security problems, making facility inspections and responding to recommendations for corrective strategies;
- Providing input on additions to or redesigns of facilities;
- Identifying the daily activities that employees believe put them most at risk for workplace violence;
- Discussions and assessments to improve policies and procedures—including complaint and suggestion programs designed to improve safety and security;

- Ensuring that there is a way to report and record incidents and near misses, and that issues are addressed appropriately;
- Ensuring that there are procedures to ensure that employees are not retaliated against for voicing concerns or reporting injuries; and
- Employee training and continuing education programs.

2. Worksite Analysis and Hazard Identification

A worksite analysis involves a mutual step-by-step assessment of the workplace to find existing or potential hazards that may lead to incidents of workplace violence. Cooperation between workers and employers in identifying and assessing hazards is the foundation of a successful violence prevention program. The assessment should be made by a team that includes senior management, supervisors and workers. 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 facility operations, process activities and potential threats. Depending on the size and structure of the organization, the team may also include representatives from operations; employee assistance; security; occupational safety and health; legal; and human resources staff. The assessment should include a records review, a review of the procedures and operations for different jobs, employee surveys and workplace security analysis.

Cooperation between workers and employers in identifying and assessing hazards is the foundation of a successful violence prevention program.

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. The assessment team should also determine how often and under

what circumstances worksite analyses should be conducted. For example, the team may determine that a comprehensive annual worksite analysis should be conducted, but require that an investigative analysis occur after every incident or near miss.

Additionally, those conducting the worksite analysis should periodically inspect the workplace and evaluate worker tasks in order to identify hazards, conditions, operations and situations that could lead to potential violence. The advice of independent reviewers, such as safety and health professionals, law enforcement or security specialists, and insurance safety auditors may be solicited to strengthen programs. These experts often provide a different perspective that serves to improve a program.

Information is generally collected through: (1) records analysis; (2) job hazard analysis; (3) employee surveys; and (4) patient/client surveys.

Records analysis and tracking

Records review is important to identify patterns of assaults or near misses that could be prevented or reduced through the implementation of appropriate controls. Records review should include medical, safety, specific threat assessments, workers' compensation and insurance records. The review should also include the OSHA Log of Work-Related Injuries and Illnesses (OSHA Form 300) if the employer is required to maintain one. In addition, incident/near-miss logs, a facility's general event or daily log and police reports should be reviewed to identify assaults relative to particular:

- Departments/Units;
- Work areas;
- Job titles;
- Activities—such as transporting patients between units or facilities, patient intake; and
- Time of day.

Possible Findings from Records Review:

	Hospital	Residential Treatment	Non-residential Treatment/ Service	Community Care	Field Workers (Home Healthcare and Social Service)
Departments/ Units	· Emergency Department · Psychiatric Unit · Geriatric Unit	· Dementia Unit · Adolescent Unit			
Work areas	· Waiting room · Nurses' station · Hallway · Treatment rooms	· Therapy room · Patient's room · Dining area · Van/Car transport	· Waiting area · Therapy room	· Kitchen · Car	· Kitchen · Car · Bedroom
Job titles	· Security guard · Nurse · Therapist · Doctor · Receptionist · Health aide · Technician	· Social worker · Therapist · Nurse · Health aide · Security guard · Driver · Technician	· Social worker · Behavioral health specialist · Nurse · Technician	· Social worker · Therapist · Health aide	· Social worker · Health aide · Child Support services · Emergency medical personnel
Activities	· Patient intake · Transferring patients from one floor to another · Meal time · Bathing · Changing of staff · Scanning for weapons	· Conducting therapy · Transitioning patients from one area to another · Driving patients · Feeding patient	· Therapy room · Client intake	· Conducting therapy · Bathing/ changing/ feeding client · Administering meds · Driving patient	· Bathing/ changing/ feeding client · Administering meds · Driving patient · Interacting with clients' families
Time of day	· After 10 PM · Meal times	· Late afternoon and evening	· No pattern	· Entry or exit	· Entry or exit · Meal times

Job Hazard Analysis

A job hazard analysis is an assessment that focuses on job tasks to identify hazards. Through review of procedures and operations connected to specific tasks or positions to identify if they contribute to hazards related to workplace violence and/or can be modified to reduce the likelihood of violence occurring, it examines the relationship between the employee, the task, tools, and the work environment. Worker participation is an essential component of the analysis. As noted in OSHA's publication on job hazard analyses,[6] priority should be given to specific types of job. For example, priority should be given to:

- Jobs with high assault rates due to workplace violence;
- Jobs that are new to an operation or have undergone procedural changes that may increase the potential for workplace violence; and
- Jobs that require written instructions, such as procedures for administering medicine, and steps required for transferring patients.

After an incident or near miss, the analysis should focus on:

- Analyzing those positions that were affected;
- Identifying if existing procedures and operations were followed and if not, why not (in some instances, not following procedures could result in more effective protections);
- Identifying if staff were adequately qualified and/or trained for the tasks required; and
- Developing, if necessary, new procedures and operations to improve staff safety and security.

Employee surveys

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

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[6] OSHA 3071-2002 (Revised). *Job Hazard Analysis.*

work processes. Detailed baseline screening surveys can help pinpoint tasks that put workers at risk. Periodic surveys—conducted at least annually or whenever operations change or incidents of workplace violence occur—help identify new or previously unnoticed risk factors and deficiencies or failures in work practices. The periodic review process should also include feedback and follow-up. The following are sample questions:

- What daily activities, if any, expose you to the greatest risk of violence?
- What, if any, work activities make you feel unprepared to respond to a violent action?
- Can you recommend any changes or additions to the workplace violence prevention training you received?
- Can you describe how a change in a patient's daily routine affected the precautions you take to address the potential for workplace violence?

Client/Patient Surveys

Clients and patients may also have valuable feedback that may enable those being served by the facility to provide useful information to design, implement, and evaluate the program. Clients and patients may be able to participate in identifying triggers to violence, daily activities that may lead to violence, and effective responses.

3. Hazard Prevention and Control

After the systematic worksite analysis is complete, the employer should take the appropriate steps to prevent or control the hazards that were identified. To do this, the employer should: (1) identify and evaluate control options for workplace hazards; (2) select effective and feasible controls to eliminate or reduce hazards; (3) implement these controls in the workplace; (4) follow up to confirm that these controls are being used and maintained properly; and (5) evaluate the effectiveness of controls and improve, expand, or update them as needed.

In the field of industrial hygiene, these steps are generally categorized, in order of effectiveness, as (1) substitution; (2) engineering controls; and (3) administrative and work practice controls. These principles, which are described in more detail below, can also be applied to the field of workplace violence. In addition, employers should ensure that, if an incident of workplace violence occurs, post-incident procedures and services are in place and/or immediately made available.

Substitution

The best way to eliminate a hazard is to eliminate it or substitute a safer work practice. While these substitutions may be difficult in the therapeutic healthcare environment, an example may be transferring a client or patient to a more appropriate facility if the client has a history of violent behavior that may not be appropriate in a less secure therapeutic environment.

Engineering controls and workplace adaptations to minimize risk

Engineering controls are physical changes that either remove the hazard from the workplace or create a barrier between the worker and the hazard. In facilities where it is appropriate, there are several engineering control measures that can effectively prevent or control workplace hazards. Engineering control strategies include: (a) using physical barriers (such as enclosures or guards) or door locks to reduce employee exposure to the hazard; (b) metal detectors; (c) panic buttons, (d) better or additional lighting; and (e) more accessible exits (where appropriate). The measures taken should be site-specific and based on the hazards identified in the worksite analysis appropriate to the specific therapeutic setting. For example, closed circuit videos and bulletproof glass may be appropriate in a hospital or other institutional setting, but not in a community care facility. Similarly, it should be noted that services performed in the field (e.g., home health or social services) often occur in private residences where some engineering controls may not be possible or appropriate.

If new construction or modifications are planned for a facility, assess any plans to eliminate or reduce security hazards.

The following are possible engineering controls that could apply in different settings. Note that this is a list of suggested measures whose appropriateness will depend on a number of factors.

Possible engineering controls for different healthcare and social service settings

<table>
<tr><th></th><th>Hospital</th><th>Residential Treatment</th><th>Non-residential Treatment/ Service</th><th>Community Care</th><th>Field Workers (Home Healthcare, Social Service)</th></tr>
<tr><td rowspan="2">Security/ silenced alarm systems</td><td colspan="3">· Panic buttons or paging system at workstations or personal alarm devices worn by employees</td><td colspan="2">· Paging system
· GPS tracking[7]
· Cell phones</td></tr>
<tr><td colspan="5">· Security/silenced alarm systems should be regularly maintained and managers and staff should fully understand the range and limitations of the system.</td></tr>
<tr><td rowspan="2">Exit routes</td><td colspan="2">· Where possible, rooms should have two exits
· Provide employee 'safe room' for emergencies
· Arrange furniture so workers have a clear exit route</td><td>· Where possible, counseling rooms should have two exits
· Arrange furniture so workers have a clear exit route</td><td colspan="2">· Managers and workers should assess homes for exit routes</td></tr>
<tr><td colspan="5">· Workers should be familiar with a site and identify the different exit routes available.</td></tr>
<tr><td>Metal detectors– hand-held or installed</td><td colspan="5">· Employers and workers will have to determine the appropriate balance of creating the suitable atmosphere for services being provided and the types of barriers put in place.
· Metal detectors should be regularly maintained and assessed for effectiveness in reducing the weapons brought into a facility.
· Staff should be appropriately assigned, and trained to use the equipment and remove weapons.</td></tr>
<tr><td rowspan="2">Monitoring systems & natural surveillance</td><td colspan="2">· Closed-circuit video – inside and outside
· Curved mirrors
· Proper placement of nurses' stations to allow visual scanning of areas
· Glass panels in doors/walls for better monitoring</td><td>· Closed-circuit video – inside and outside
· Curved mirrors
· Glass panels in doors for better monitoring</td><td></td><td></td></tr>
<tr><td colspan="5">· Employers and workers will have to determine the appropriate balance of creating the suitable atmosphere for services being provided and the types of barriers put in place.
· Staff should know if video monitoring is in use or not and whether someone is always monitoring the video or not.</td></tr>
</table>

[7] Employers and workers should determine the most effective method for ensuring the safety of workers without negatively impacting working conditions.

	Hospital	Residential Treatment	Non-residential Treatment/ Service	Community Care	Field Workers (Home Healthcare, Social Service)
Barrier protection	· Enclosed receptionist desk with bulletproof glass · Deep counters at nurses' stations · Lock doors to staff counseling and treatment rooms · Provide lockable (or keyless door systems) and secure bathrooms for staff members (with locks on the inside)—separated from patient/client and visitor facilities · Lock all unused doors to limit access, in accord with local fire codes	· Deep counters in offices · Provide lockable (or keyless door systems) and secure bathrooms for staff members (with locks on the inside)—separated from patient/client and visitor facilities · Lock all unused doors to limit access, in accord with local fire codes	· Deep counters · Provide lockable (or keyless door systems) and secure bathrooms for staff members (with locks on the inside)—separated from patient/client and visitor facilities		
	· Employers and workers will have to determine the appropriate balance of creating the suitable atmosphere for the services being provided and the types of barriers put in place.				

	Hospital	Residential Treatment	Non-residential Treatment/ Service	Community Care	Field Workers (Home Healthcare, Social Service)
Patient/client areas	· Establish areas for patients/ clients to de-escalate · Provide comfortable waiting areas to reduce stress · Divide waiting areas to limit the spreading of agitation among clients/ visitors	· Establish areas for patients/ clients to de-escalate · Provide comfortable waiting areas to reduce stress · Assess staff rotations in facilities where clients become agitated by unfamiliar staff	· Provide comfortable waiting areas to reduce stress	· Establish areas for patients/ clients to de-escalate	· Establish areas for patients/ clients to de-escalate
	· Employers and workers will have to determine the appropriate balance of creating the suitable atmosphere for the services being provided and the types of barriers put in place.				
Furniture, materials & maintenance	· Secure furniture and other items that could be used as weapons · Replace open hinges on doors with continuous hinges to reduce pinching hazards · Ensure cabinets and syringe drawers have working locks · Pad or replace sharp edged objects (such as metal table frames) · Consider changing or adding materials to reduce noise in certain areas · Recess any hand rails, drinking fountains and any other protrusions · Smooth down or cover any sharp surfaces			· When feasible, secure furniture or other items that could be used as weapons · Ensure cabinets and syringe drawers have working locks · Pad or replace sharp edged objects (such as metal table frames) · Ensure carrying equipment for medical equipment, medicines and valuables have working locks	· Ensure carrying equipment for medical equipment, medicines and valuables have working locks
	· Employers and workers will have to establish a balance between creating the appropriate atmosphere for the services being provided and securing furniture.				

	Hospital	Residential Treatment	Non-residential Treatment/ Service	Community Care	Field Workers (Home Healthcare, Social Service)
Lighting	· Install bright, effective lighting—both indoors and outdoors on the grounds, in parking areas and walkways			· Ensure lighting is adequate in both the indoor and outdoor areas	· Work with client to ensure lighting is adequate in both the indoor and outdoor areas
	· Ensure burned out lights are replaced immediately. · While lighting should be effective it should not be harsh or cause undue glare.				
Travel vehicles	· Ensure vehicles are properly maintained · Where appropriate, consider physical barrier between driver and patients			· Ensure vehicles are properly maintained	

Administrative and work practice controls

Administrative and work practice controls are appropriate when engineering controls are not feasible or not completely protective. These controls affect the way staff perform jobs or tasks. Changes in work practices and administrative procedures can help prevent violent incidents. As with engineering controls, the practices chosen to abate workplace violence should be appropriate to the type of site and in response to hazards identified.

In addition to the specific measures listed below, training for administrative and treatment staff should include therapeutic procedures that are sensitive to the cause and stimulus of violence. For example, research has shown that Trauma Informed Care is a treatment technique that has been successfully instituted in inpatient psychiatric units as a way to reduce patient violence, and the need for seclusion and restraint. As explained by the Substance Abuse and Mental Health Services Administration, trauma-informed services are based on an understanding of the vulnerabilities or triggers of trauma for survivors and can be more supportive than traditional service delivery approaches, thus avoiding re-traumatization.[8]

[8] Referenced on the Substance Abuse and Mental Health Services Administration's website on February 25, 2013 (www.samhsa.gov/nctic).

The following are possible administrative controls that could apply in different settings.

Possible administrative and work practice controls for different healthcare and social service settings

<table>
<tr><th></th><th>Hospital</th><th>Residential Treatment</th><th>Non-residential Treatment/Service</th><th>Community Care</th><th>Field Workers (Home Healthcare, Social Service)</th></tr>
<tr><td>Workplace violence response policy</td><td colspan="5">· Clearly state to patients, clients, visitors and workers that violence is not permitted and will not be tolerated.
· Such a policy makes it clear to workers that assaults are not considered part of the job or acceptable behavior.</td></tr>
<tr><td rowspan="2">Tracking workers'</td><td></td><td>Traveling workers should:
· have specific log-in and log-out procedures
· be required to contact the office after each visit and managers should have procedures to follow-up if workers fail to do so</td><td></td><td colspan="2">Workers should:
· have specific log-in and log-out procedures
· be required to contact the office after each visit and managers should have procedures to follow-up if workers fail to do so
· be given discretion as to whether or not they begin or continue a visit if they feel threatened or unsafe</td></tr>
<tr><td colspan="5">· Log-in/log-out procedures should include:
· the name and address of client visited;
· the scheduled time and duration of visit;
· a contact number;
· a code word used to inform someone of an incident/threat;
· worker's vehicle description and license plate number;
· details of any travel plans with client;
· contacting office/supervisor with any changes.</td></tr>
<tr><td>Tracking clients with a known history of violence</td><td colspan="2">· Supervise the movement of patients throughout the facility
· Update staff in shift report about violent history or incident</td><td>· Update staff in shift report about violent history or incident</td><td colspan="2">· Report all violent incidents to employer</td></tr>
</table>

[9] Massachusetts Department of Mental Health Task Force on Staff and Client Safety. (2011). Report of the Massachusetts Department of Mental Health Task Force on Staff and Client Safety.

	Hospital	Residential Treatment	Non-residential Treatment/Service	Community Care	Field Workers (Home Healthcare, Social Service)

	· Determine the behavioral history of new and transferred patients and clients to learn about any past violent or assaultive behaviors.
	  · Identify any event triggers for clients, such as certain dates or visitors.
	  · Identify the type of violence including severity, pattern and intended purpose.
	  · Information gained should be used to formulate individualized plans for early identification and prevention of future violence.
	· Establish a system—such as chart tags, log books or verbal census reports—to identify patients and clients with a history of violence and identify triggers and the best responses and means of de-escalation.
	· Ensure workers know and follow procedures for updates to patients' and clients' behavior.
	· Ensure patient and client confidentiality is maintained.
	· Update as needed.
	· If stalking is suspected, consider varying check-in and check-out times for affected workers and plan different travel routes for those workers.				

Working alone or in secure areas	· Treat and interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality · Ensure workers are not alone when performing intimate physical examinations of patients · Advise staff to exercise extra care in elevators and stairwells · Provide staff members with security escorts to parking areas during evening/late hours— Ensure these areas are well lit and highly visible	· Advise staff to exercise extra care in elevators, stairwells · Provide staff members with security escorts to parking areas during evening/late hours. Ensure these areas are well lit and highly visible	· Ensure workers have means of communication—either cell phones of panic buttons · Develop policy to determine when a buddy system should be implemented	· Advise staff to exercise extra care in unfamiliar residences · Workers should be given discretion to receive backup assistance by another worker or law enforcement officer · Workers should be given discretion as to whether or not they begin or continue a visit if they feel threatened or unsafe · Ensure workers have means of communication—either cell phones or panic buttons	
	· Limit workers from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable. · Establish policies and procedures for secured areas and emergency evacuations. · Use the "buddy system," especially when personal safety may be threatened.				
Reporting	· Require workers to report all assaults or threats to a supervisor or manager (for example, through a confidential interview). Keep logbooks and reports of such incidents to help determine any necessary actions to prevent recurrences. · Establish a liaison with local police, service providers who can assist (e.g., counselors) and state prosecutors. When needed, give police physical layouts of facilities to expedite investigations.				

	Hospital	Residential Treatment	Non-residential Treatment/Service	Community Care	Field Workers (Home Healthcare, Social Service)
Entry procedures	· Provide responsive, timely information to those waiting; adopt measures to reduce waiting times · Institute sign-in procedures and visitor passes · Enforce visitor hours and procedures for being in the hospital · Have a "restricted visitors" list for patients with a history of violence/ gang activity; make copies available to security, nurses, and sign-in clerk	· Institute sign-in procedures with passes for visitors · Enforce visitor hours and procedures · Establish a list of "restricted visitors" for patients with a history of violence or gang activity; make copies available at security checkpoints, nurses' stations and visitor sign-in areas	· Provide responsive, timely information to those waiting; adopt measures to reduce waiting times	· Ensure workers determine how best to enter facilities	· Ensure workers determine how best to enter clients' homes
Incident response/ high risk activities	· Use properly trained security officers and counselors to respond to aggressive behavior; follow written security procedures · Ensure that adequate and qualified staff members are available at all times, especially during high-risk times such as patient transfers, emergency responses, mealtimes and at night · Ensure that adequate and qualified staff members are available to disarm and de-escalate patients if necessary · Assess changing client routines and activities to reduce or eliminate the possibility of violent outbursts		· Use properly trained security officers and counselors to respond to aggressive behavior; follow written security procedures		· Ensure assistance if children will be removed from the home

	Hospital	Residential Treatment	Non-residential Treatment/Service	Community Care	Field Workers (Home Healthcare, Social Service)
	· Advise workers of company procedures for requesting police assistance or filing charges when assaulted—and assist them in doing so if necessary. · Provide management support during emergencies. Respond promptly to all complaints. · Ensure that adequately trained staff members and counselors are available to de-escalate a situation and counsel patients. · Prepare contingency plans to treat clients who are "acting out" or making verbal or physical attacks or threats. · Emergency action plans should be developed to ensure that workers know how to call for help or medical assistance.				
Employee uniforms/ dress	· Provide staff with identification badges, preferably without last names, to readily verify employment. · Discourage workers from wearing necklaces or chains to help prevent possible strangulation in confrontational situations. · Discourage workers from wearing expensive jewelry or carrying large sums of money. · Discourage workers from carrying keys or other items that could be used as weapons. · Encourage the use of head netting/cap so hair cannot be grabbed and used to pull or shove workers.				
Facility & work procedures	· Survey facility periodically to remove tools or possessions left by visitors or staff that could be used inappropriately by patients · Survey facilities regularly to ensure doors that should be locked are locked—smoking policies should not allow these doors to be propped open · Keep desks and work areas free of items, including extra pens and pencils, glass photo frames, etc.	· Survey facility periodically to remove tools or possessions left by visitors or staff that could be used inappropriately by patients · Keep desks and work areas free of items, including extra pens and pencils, glass photo frames, etc.	· Survey facility periodically to remove tools or possessions left by visitors or staff that could be used inappro-priately by patients · Establish daily work plans to keep a designated contact person informed about employees' whereabouts throughout the workday; have a contact person follow up if an employee does not report in as expected	· Have clear contracts on how home visits will be conducted, the presence of others in the home during visits and the refusal to provide services in clearly hazardous situations · Establish daily work plans to keep a designated contact person informed about employees' whereabouts throughout the workday; have a contact person follow up if an employee does not report in as expected	

	Hospital	Residential Treatment	Non-residential Treatment/Service	Community Care	Field Workers (Home Healthcare, Social Service)
Transportation procedures	· Develop safety procedures that specifically address the transport of patients. · Ensure that workers transporting patients have an effective and reliable means of communicating with their home office			· Develop safety procedures that specifically address the transport of patients. · Ensure that workers transporting patients have an effective and reliable means of communicating with their home office	

Post-incident procedures and services

Post-incident response and evaluation are important components to an effective violence prevention program. Investigating incidents of workplace violence thoroughly 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. Root causes, if not corrected, will inevitably recreate the conditions for another incident to occur.

When an incident occurs, the immediate first steps are to provide first aid and emergency care for the injured worker(s) and to take any measures necessary to prevent others from being injured. All workplace violence programs should provide comprehensive treatment for workers who are victimized personally or may be traumatized by witnessing a workplace violence incident. Injured staff should receive prompt treatment and psychological evaluation whenever an assault takes place, regardless of its severity—free of charge. Also, injured workers should be provided transportation to medical care if not available on site.

Victims of workplace violence could suffer a variety of consequences in addition to their actual physical injuries. These may include:

- Short- and long-term psychological trauma;
- Fear of returning to work;
- Changes in relationships with coworkers and family;
- Feelings of incompetence, guilt, powerlessness; and
- Fear of criticism by supervisors or managers.

Consequently, a strong follow-up program for these workers will not only help them address these problems but also help prepare them to confront or prevent future incidents of violence.

Several types of assistance can be incorporated into the post-incident response. For example, trauma-crisis counseling, critical-incident stress debriefing or employee assistance programs may be provided to assist victims. As explained by the Substance Abuse and Mental Health Services Administration, trauma-informed services are based on an understanding of the vulnerabilities or triggers of trauma for survivors and can be more supportive than traditional service delivery approaches, thus avoiding re-traumatization.[10] Whether the support is trauma-informed or not, certified employee assistance professionals, psychologists, psychiatrists, clinical nurse specialists or social workers should provide this counseling. Alternatively, the employer may refer staff victims to an outside specialist. In addition, the employer may establish an employee counseling service, peer counseling, or support groups.

Counselors should be well trained and have a good understanding of the issues and consequences of assaults and other aggressive, violent behavior. Appropriate and promptly rendered post-incident debriefings and counseling reduce acute psychological trauma and general stress levels among victims and witnesses. In addition, this type of counseling educates staff about workplace violence and positively influences workplace and organizational cultural norms to reduce trauma associated with future incidents.

Investigation of Incidents

Once these immediate needs are taken care of, the investigation should begin promptly. The basic steps in conducting incident investigations are:

1. *Report as required.* Determine who needs to be notified, both within the organization and outside (e.g., authorities), when there is an incident. Understand what types of

[10] Referenced on the Substance Abuse and Mental Health Services Administration's website on February 25, 2013 (www.samhsa.gov/nctic).

incidents must be reported, and what information needs to be included. If the incident involves hazardous materials additional reporting requirements may apply.

2. *Involve workers in the incident investigation.* The employees who work most closely in the area where the event occurred may have special insight into the causes and solutions.

3. *Identify Root Causes:* Identify the root causes of the incident. Don't stop an investigation at "worker error" or "unpredictable event." Ask "why" the patient or client acted, "why" the worker responded in a certain way, etc.

4. *Collect and review other information.* Depending on the nature of the incident, records related to training, maintenance, inspections, audits, and past incident reports may be relevant to review.

5. *Investigate Near Misses.* In addition to investigating all incidents resulting in a fatality, injury or illness, any near miss (a situation that could potentially have resulted in death, injury, or illness) should be promptly investigated as well. Near misses are caused by the same conditions that produce more serious outcomes, and signal that some hazards are not being adequately controlled, or that previously unidentified hazards exist.

Identify the root causes of the incident. Don't stop an investigation at "worker error" or "unpredictable event." Ask "why" the patient or client acted, "why" the worker responded in a certain way, etc.

4. Safety and Health Training

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). However, employers should ensure that worker safety is a separate component that is thoroughly addressed.

Training for all workers

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. The training program should involve all workers, including contract workers, supervisors, and managers. Workers who may face safety and security hazards should receive formal instruction on any specific or potential hazards associated with the unit or job and the facility. Such training may include information on the types of injuries or problems identified in the facility and the methods to control the specific hazards. It may also include instructions to limit physical interventions in workplace altercations whenever possible.

Every worker should understand the concept of "universal precautions for violence"— that is, that violence should be expected but can be avoided or mitigated through preparation. In addition, workers should understand the importance of a culture of respect, dignity, and active mutual engagement in preventing workplace violence.

New and reassigned workers should receive an initial orientation before being assigned their job duties. All workers should receive required training annually. In high-risk settings and institutions, refresher training may be needed more frequently, perhaps monthly or quarterly, to effectively reach and inform all workers. Visiting staff, such as physicians, should receive the same training as permanent staff and contract workers. Qualified trainers should instruct at the comprehension level appropriate for the staff. Effective training programs should involve role-playing, simulations and drills.

Training topics

Training topics may include management of assaultive behavior, professional/police assault-response training, or personal safety training on how to prevent and avoid assaults.

A combination of training programs may be used, depending on the severity of the risk.

In general, training should cover the policies and procedures for a facility as well as de-escalation and self-defense techniques. Both de-escalation and self-defense training should include a hands-on component. The following provides a list of possible topics:

- The workplace violence prevention policy;
- Risk factors that cause or contribute to assaults;
- Policies and procedures for documenting patients' or clients' change in behavior;
- The location, operation, and coverage of safety devices such as alarm systems, along with the required maintenance schedules and procedures;
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults;
- Ways to recognize, prevent or diffuse volatile situations or aggressive behavior, manage anger and appropriately use medications;
- Ways to deal with hostile people other than patients and clients, such as relatives and visitors;
- Proper use of safe rooms—areas where staff can find shelter from a violent incident;
- A standard response action plan for violent situations, including the availability of assistance, response to alarm systems and communication procedures;
- Self-defense procedures where appropriate;
- Progressive behavior control methods and when and how to apply restraints properly and safety when necessary;
- Ways to protect oneself and coworkers, including use of the "buddy system";
- Policies and procedures for reporting and recordkeeping;
- Policies and procedures for obtaining medical care, trauma-informed care, counseling, workers' compensation or legal assistance after a violent episode or injury.

Training for supervisors and managers

Supervisors and managers must be trained to recognize high-risk situations, so they can ensure that workers are not placed in assignments that compromise their safety. Such training should include encouraging workers to report incidents and to seek the appropriate care after experiencing a violent incident.

Supervisors and managers must be trained to recognize high-risk situations, so they can ensure that workers are not placed in assignments that compromise their safety.

Supervisors and managers should learn how to reduce safety hazards and ensure that workers receive appropriate training. Following training, supervisors and managers should be able to recognize a potentially hazardous situation and make any necessary changes in the physical plant, patient care treatment program and staffing policy, and procedures to reduce or eliminate the hazards.

Training for security personnel

Security personnel need specific training from the hospital or clinic, including the psychological components of handling aggressive and abusive clients, and ways to handle aggression and defuse hostile situations.

Evaluation of training

The training program should also include an evaluation. At least annually, the team or coordinator responsible for the program should review its content, methods and the frequency of training. Program evaluation may involve supervisor and employee interviews, testing, observing and reviewing reports of behavior of individuals in threatening situations.

5. Recordkeeping and Program Evaluation

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.

Accurate records of injuries, illnesses, incidents, assaults, hazards, corrective actions, patient histories and training can help employers determine the severity of the problem; identify any developing trends or patterns in particular locations, jobs or departments; evaluate methods of hazard control; identify training needs and develop solutions for an effective program. Records can be especially useful to large organizations and for members of a trade association that "pool" data. Key records include:

- *OSHA Log of Work-Related Injuries and Illnesses (OSHA Form 300).* Covered employers are required to prepare and maintain records of serious occupational injuries and illnesses, using the OSHA 300 Log. As of January 2015, all employers must report: (1) all work-related fatalities within 8 hours and (2) all work-related inpatient hospitalizations, all amputations and all losses of an eye within 24 hours. Injuries caused by assaults must be entered on the log if they meet the recording criteria.[11]
- *Medical reports of work injury, workers' compensation reports and supervisors' reports for each recorded assault.* These records should describe the type of assault, such as an unprovoked sudden attack or patient-to-patient altercation, who was assaulted, and all other circumstances of the incident. The records should include a description of the environment or location, lost work time that resulted and the nature of injuries sustained. These medical records are confidential documents and should be kept in a locked location under the direct responsibility of a healthcare professional.
- *Records of incidents of abuse, reports conducted by security personnel, verbal attacks or aggressive behavior that may be threatening*, such as pushing or shouting and acts of aggression toward other clients. This may be kept as part of an assaultive incident report. Ensure that the affected department evaluates these records routinely.
- *Information on patients with a history of past violence, drug abuse or criminal activity recorded on the patient's chart.* Anyone who cares for a potentially aggressive, abusive or

[11] 29 CFR Part 1904, revised 2014.

violent client should be aware of the person's background and history, including triggers and de-escalation responses. Log the admission of violent patients to help determine potential risks. Log violent events on patients' charts and flagged charts.[12]

- *Documentation of minutes of safety meetings, records of hazard analyses and corrective actions recommended and taken.*
- *Records of all training programs, attendees, and qualifications of trainers.*

Elements of a program evaluation

As part of their overall program, employers should evaluate their safety and security measures. Top management should review the program regularly and, with each incident, to evaluate its success. Responsible parties (including managers, supervisors and employees) should reevaluate policies and procedures on a regular basis to identify deficiencies and take corrective action.

Management should share workplace violence prevention evaluation reports with all workers. Any changes in the program should be discussed at regular meetings of the safety committee, union representatives or other employee groups.

All reports should protect worker and patient confidentiality either by presenting only aggregate data or by removing personal identifiers if individual data are used.

Processes involved in an evaluation include:

- Establishing a uniform violence reporting system and regular review of reports;
- Reviewing reports and minutes from staff meetings on safety and security issues;
- Analyzing trends and rates in illnesses, injuries or fatalities caused by violence relative to initial or "baseline" rates;
- Measuring improvement based on lowering the frequency and severity of workplace violence;

[12] Proper patient confidentiality must be maintained.

- Keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate how well they work;
- Surveying workers before and after making job or worksite changes or installing security measures or new systems to determine their effectiveness;
- Tracking recommendations through to completion;
- Keeping abreast of new strategies available to prevent and respond to violence in the healthcare and social service fields as they develop;
- Surveying workers periodically to learn if they experience hostile situations in performing their jobs;
- Complying with OSHA and state requirements for recording and reporting injuries, illnesses, and fatalities; and
- Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving worker safety.

Workplace Violence Program Checklists

These checklists can help you or your workplace violence/crime prevention committee evaluate the workplace and job tasks to identify situations that may place workers at risk of assault. It is not designed for a specific industry or occupation, and may be used for any workplace. Adapt the checklist to fit your own needs. It is very comprehensive and not every question will apply to your workplace—if the question does not apply, either delete or write "N/A" in the NOTES column. Add any other questions that may be relevant to your worksite.

1. RISK FACTORS FOR WORKPLACE VIOLENCE

Cal/OSHA and NIOSH have identified the following risk factors that may contribute to violence in the workplace. If you have one or more of these risk factors in your workplace, there may be a potential for violence.

	YES	NO	Notes/Follow-up Action
Do employees have contact with the public?			
Do they exchange money with the public?			
Do they work alone?			
Do they work late at night or during early morning hours?			
Is the workplace often understaffed?			
Is the workplace located in an area with a high crime rate?			
Do employees enter areas with a high crime rate?			
Do they have a mobile workplace (patrol vehicle, work van, etc.)?			
Do they deliver passengers or goods?			
Do employees perform jobs that might put them in conflict with others?			
Do they ever perform duties that could upset people (deny benefits, confiscate property, terminate child custody, etc.)?			
Do they deal with people known or suspected of having a history of violence?			
Do any employees or supervisors have a history of assault, verbal abuse, harassment, or other threatening behavior?			
Other risk factors – please describe:			

2. INSPECTING WORK AREAS

- Who is responsible for building security?_____
  _____
- Are workers told or can they identify who is responsible for security? Yes No

You or your workplace violence/crime prevention committee should now begin a "walkaround" inspection to identify potential security hazards. This inspection can tell you which hazards are already well controlled, and what control measures need to be added. Not all of the following questions may be answered through simple observation. You may also need to talk to workers or investigate in other ways.

	All Areas	Some Areas	Few Areas	No Areas	NOTES/FOLLOW-UP ACTION
Are nametags or ID cards required for employees (omitting personal information such as last name and home address)?					
Are workers notified of past violent acts in the workplace?					
Are trained security and counseling personnel accessible to workers in a timely manner?					
Do security and counseling personnel have sufficient authority to take all necessary action to ensure worker safety?					
Is there an established liaison with state police and/or local police and counseling agencies?					
Are bullet-resistant windows or similar barriers used when money is exchanged with the public?					
Are areas where money is exchanged visible to others who could help in an emergency? (For example, can you see cash register areas from outside?)					
Is a limited amount of cash kept on hand, with appropriate signs posted?					
Could someone hear a worker who calls for help?					
Can employees observe patients or clients in waiting areas?					
Do areas used for patient or client interviews allow co-workers to observe any problems?					
Are waiting areas and work areas free of objects that could be used as weapons?					
Are chairs and furniture secured to prevent their use as weapons?					
Is furniture in waiting areas and work areas arranged to prevent entrapment of workers?					
Are patient or client waiting areas designed to maximize comfort and minimize stress?					

	All Areas	Some Areas	Few Areas	No Areas	NOTES/FOLLOW-UP ACTION
Are patients or clients in waiting areas clearly informed how to use the department's services so they will not become frustrated?					
Are waiting times for patient or client services kept short to prevent frustration?					
Are private, locked restrooms available for employees?					
Is there a secure place for workers to store personal belongings?					

3. INSPECTING EXTERIOR BUILDING AREAS

	Yes	No	NOTES/FOLLOW-UP ACTION
Do workers feel safe walking to and from the workplace?			
Are the entrances to the building clearly visible from the street?			
Is the area surrounding the building free of bushes or other hiding places?			
Is lighting bright and effective in outside areas?			
Are security personnel provided outside the building?			
Is video surveillance provided outside the building?			
Are remote areas secured during off shifts?			
Is a buddy escort system required to remote areas during off shifts?			
Are all exterior walkways visible to security personnel?			

4. INSPECTING PARKING AREAS

	Yes	No	NOTES/FOLLOW-UP ACTION
Is there a nearby parking lot reserved for employees only?			
Is the parking lot attended or otherwise secured?			
Is the parking lot free of blind spots and is landscaping trimmed back to prevent hiding places?			
Is there enough lighting to see clearly in the parking lot and when walking to the building?			
Are security escorts available to employees walking to and from the parking lot?			

5. SECURITY MEASURES

Does the workplace have:	In Place	Should Add	Doesn't Apply	NOTES/FOLLOW-UP ACTION
Physical barriers (plexiglass partitions, bullet-resistant customer window, etc.)?				
Security cameras or closed-circuit TV in high-risk areas?				
Panic buttons?				
Alarm systems?				
Metal detectors?				
Security screening device?				
Door locks?				
Internal telephone system to contact emergency assistance?				
Telephones with an outside line programmed for 911?				
Two-way radios, pagers, or cellular telephones?				
Security mirrors (e.g., convex mirrors)?				
Secured entry (e.g., "buzzers")?				
Personal alarm devices?				
"Drop safes" to limit the amount of cash on hand?				
Broken windows repaired promptly?				
Security systems, locks, etc. tested on a regular basis and repaired promptly when necessary?				

6. COMMENTS

_____

_____

_____

_____

Checklist completed by: _____ Date: _____

Department/Location: _____

Phone Number: _____

Workplace Violence Prevention Program Assessment Checklist

Use this checklist as part of a regular safety and health inspection or audit to be conducted by the Health and Safety, Crime/Workplace Violence Prevention Coordinator, or joint labor/management committee. If a question does not apply to the workplace, then write "N/A" (not applicable) in the notes column. Add any other questions that may be appropriate.

	Yes	No	NOTES
STAFFING			
Is there someone responsible for building security?			
Who is it?			
Are workers told who is responsible for security?			
Is adequate and trained staffing available to protect workers who are in potentially dangerous situations?			
Are there trained security personnel accessible to workers in a timely manner?			
Do security personnel have sufficient authority to take all necessary action to ensure worker safety?			
Are security personnel provided outside the building?			
Is the parking lot attended or otherwise secure?			
Are security escorts available to walk employees to and from the parking lot?			

	Yes	No	NOTES
TRAINING			
Are workers trained in the emergency response plan (for example, escape routes, notifying the proper authorities)?			
Are workers trained to report violent incidents or threats?			
Are workers trained in how to handle difficult clients or patients?			
Are workers trained in ways to prevent or defuse potentially violent situations?			
Are workers trained in personal safety and self-defense?			
FACILITY DESIGN			
Are there enough exits and adequate routes of escape?			
Can exit doors be opened only from the inside to prevent unauthorized entry?			
Is the lighting adequate to see clearly in indoor areas?			
Are there employee-only work areas that are separate from public areas?			
Is access to work areas only through a reception area?			
Are reception and work areas designed to prevent unauthorized entry?			
Could someone hear a worker call for help?			
Can workers observe patients or clients in waiting areas?			
Do areas used for patient or client interviews allow co-workers to observe any problems?			
Are waiting and work areas free of objects that could be used as weapons?			
Are chairs and furniture secured to prevent their use as weapons?			
Is furniture in waiting and work areas arranged to prevent workers from becoming trapped?			
Are patient or client areas designed to maximize comfort and minimize stress?			
Is a secure place available for workers to store their personal belongings?			
Are private, locked restrooms available for staff?			

	Yes	No	NOTES
SECURITY MEASURES – Does the workplace have?			
Physical barriers (Plexiglas partitions, elevated counters to prevent people from jumping over them, bullet-resistant customer windows, etc.)?			
Security cameras or closed-circuit TV in high-risk areas?			
Panic buttons – (portable or fixed)			
Alarm systems?			
Metal detectors?			
X-ray machines?			
Door locks?			
Internal phone system to activate emergency assistance?			
Phones with an outside line programmed to call 911?			
Security mirrors (convex mirrors)?			
Secured entry (buzzers)?			
Personal alarm devices?			
OUTSIDE THE FACILITY			
Do workers feel safe walking to and from the workplace?			
Are the entrances to the building clearly visible from the street?			
Is the area surrounding the building free of bushes or other hiding places?			
Is video surveillance provided outside the building?			
Is there enough lighting to see clearly outside the building?			
Are all exterior walkways visible to security personnel?			
Is there a nearby parking lot reserved for employees only?			
Is the parking lot free of bushes or other hiding places?			
Is there enough lighting to see clearly in the parking lot and when walking to the building?			
Have neighboring facilities and businesses experienced violence or crime?			

	Yes	No	NOTES
WORKPLACE PROCEDURES			
Are employees given maps and clear directions in order to navigate the areas where they will be working?			
Is public access to the building controlled?			
Are floor plans posted showing building entrances, exits, and location of security personnel?			
Are these floor plans visible only to staff and not to outsiders?			
Is other emergency information posted, such as the telephone numbers?			
Are special security measures taken to protect people who work late at night (escorts, locked entrances, etc.)?			
Are visitors or clients escorted to offices for appointments?			
Are authorized visitors to the building required to wear ID badges?			
Are identification tags required for staff (omitting personal information such as the person's last name and social security number)?			
Are workers notified of past violent acts by particular clients, patients, etc.?			
Is there an established liaison with local police and counseling agencies?			
Are patients or clients in waiting areas clearly informed how to use the department's services so they will not become frustrated?			
Are waiting times for patient or client services kept short to prevent frustration?			
Are broken windows and locks repaired promptly?			
Are security devices (locks, cameras, alarms, etc.) tested on a regular basis and repaired promptly when necessary?			
FIELD WORK – Staffing:			
Are escorts or "buddies" provided for people who work in potentially dangerous situations?			
Is assistance provided to workers in the field in a timely manner when requested?			
FIELD WORK – Training:			
Are workers briefed about the area in which they will be working (gang colors, neighborhood culture, language, drug activity, etc.)?			

	Yes	No	NOTES
Can workers effectively communicate with people they meet in the field (same language, etc.)?			
Are people who work in the field late at night or early mornings advised about special precautions to take?			
FIELD WORK – Work Environment:			
Is there enough lighting to see clearly in all areas where workers must go?			
Are there safe places for workers to eat, use the restroom, store valuables, etc.?			
Are there places where workers can go for protection in an emergency?			
Is safe parking readily available for employees in the field?			
FIELD WORK – Security Measures:			
Are workers provided two-way radios, pagers, or cellular phones?			
Are workers provided with personal alarm devices or portable panic buttons?			
Are vehicle door and window locks controlled by the driver?			
Are vehicles equipped with physical barriers (Plexiglas partitions, etc.)?			
FIELD WORK – Work Procedures:			
Are employees given maps and clear directions for covering the areas where they will be working?			
Are employees given alternative routes to use in neighborhoods with a high crime rate?			
Does a policy exist to allow employees to refuse service to clients or customers (in the home, etc.) in a hazardous situation?			
Has a liaison with the police been established?			
Do workers avoid carrying unnecessary items that someone could use as weapon against them?			
Does the employer provide a safe vehicle or other transportation for use in the field?			
Are vehicles used in the field routinely inspected and kept in good working order?			
Is there always someone who knows where each employee is?			
Are nametags required for workers in the field (omitting personal information such as last name and social security number)?			
Are workers notified of past violent acts by particular clients, patients, etc.?			

	Yes	No	NOTES
FIELD WORK – Are special precautions taken when workers:			
Have to take something away from people (remove children from the home)?			
Have contact with people who behave violently?			
Use vehicles or wear clothing marked with the name of an organization that the public may strongly dislike?			
Perform duties inside people's homes?			
Have contact with dangerous animals (dogs, etc.)?			

Adapted from the workplace violence prevention program checklist, California Department of Human Resources, see www.calhr.ca.gov/Documents/model-workplace-violence-and-bullying-prevention-program.pdf (last accessed November 25, 2014).

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Workers' Rights

Workers have the right to:

- Working conditions that do not pose a risk of serious harm.
- Receive information and training (in a language and vocabulary the worker understands) about workplace hazards, methods to prevent them, and the OSHA standards that apply to their workplace.
- Review records of work-related injuries and illnesses.
- File a complaint asking OSHA to inspect their workplace if they believe there is a serious hazard or that their employer is not following OSHA's rules. OSHA will keep all identities confidential.
- Exercise their rights under the law without retaliation, including reporting an injury or raising health and safety concerns with their employer or OSHA. If a worker has been retaliated against for using their rights, they must file a complaint with OSHA as soon as possible, but no later than 30 days.

For more information, see OSHA's Workers page.

OSHA Assistance, Services and Programs

OSHA has a great deal of information to assist employers in complying with their responsibilities under OSHA law. Several OSHA programs and services can help employers identify and correct job hazards, as well as improve their injury and illness prevention program.

Establishing an Injury and Illness Prevention Program

The key to a safe and healthful work environment is a comprehensive injury and illness prevention program.

Injury and illness prevention programs are systems that can substantially reduce the number and severity of workplace injuries and illnesses, while reducing costs to employers. Thousands of employers across the United States already manage safety using injury and illness prevention programs, and OSHA believes that all employers can and should do the same. Thirty-four states have requirements or voluntary guidelines for workplace injury and illness prevention programs. Most successful injury and illness prevention programs are based on a common set of key elements. These include management leadership, worker participation, hazard identification, hazard prevention and control, education and training, and program evaluation and improvement. Visit OSHA's Injury and Illness Prevention Programs web page at www.osha.gov/dsg/topics/safetyhealth for more information.

Compliance Assistance Specialists

OSHA has compliance assistance specialists throughout the nation located in most OSHA offices. Compliance assistance specialists can provide information to employers and workers about OSHA standards, short educational programs on specific hazards or OSHA rights and responsibilities, and information on additional compliance assistance resources. For more details, visit www.osha.gov/dcsp/compliance_assistance/cas.html or call 1-800-321-OSHA (6742) to contact your local OSHA office.

Free On-site Safety and Health Consultation Services for Small Business

OSHA's On-site Consultation Program offers free and confidential advice to small and medium-sized businesses in all states across the country, with priority given to high-hazard worksites. Each year, responding to requests from small employers looking to create or improve their safety and health management programs, OSHA's On-site Consultation Program conducts over 29,000 visits to small business worksites covering over 1.5 million workers across the nation.

On-site consultation services are separate from enforcement and do not result in penalties or citations. Consultants from state agencies or universities work with employers to identify workplace hazards, provide advice on compliance with OSHA standards, and assist in establishing safety and health management programs.

For more information, to find the local On-site Consultation office in your state, or to request a brochure on Consultation Services, visit www.osha.gov/consultation, or call 1-800-321-OSHA (6742).

Under the consultation program, certain exemplary employers may request participation in OSHA's **Safety and Health Achievement Recognition Program (SHARP).** Eligibility for participation includes, but is not limited to, receiving a full-service, comprehensive consultation visit, correcting all identified hazards and developing an effective safety and health management program. Worksites that receive SHARP recognition are exempt from programmed inspections during the period that the SHARP certification is valid.

Cooperative Programs

OSHA offers cooperative programs under which businesses, labor groups and other organizations can work cooperatively with OSHA. To find out more about any of the following programs, visit www.osha.gov/cooperativeprograms.

Strategic Partnerships and Alliances

The OSHA Strategic Partnerships (OSP) provide the opportunity for OSHA to partner with employers, workers, professional or trade associations, labor organizations, and/or other interested stakeholders. OSHA Partnerships are formalized through unique agreements designed to encourage, assist, and recognize partner efforts to eliminate serious hazards and achieve model workplace safety and health practices. Through the Alliance Program, OSHA works with groups committed to worker safety and health to prevent workplace fatalities, injuries and illnesses by developing compliance assistance tools and resources to share with workers and employers, and educate workers and employers about their rights and responsibilities.

Voluntary Protection Programs (VPP)

The VPP recognize employers and workers in private industry and federal agencies who have implemented effective safety and health management programs and maintain injury and illness rates below the national average for their respective industries. In VPP, management, labor, and OSHA work cooperatively and proactively to prevent fatalities, injuries, and illnesses through a system focused on: hazard prevention and control, worksite analysis, training, and management commitment and worker involvement.

Occupational Safety and Health Training

The OSHA Training Institute partners with 27 OSHA Training Institute Education Centers at 42 locations throughout the United States to deliver courses on OSHA standards and occupational safety and health topics to thousands of students a year. For more information on training courses, visit www.osha.gov/otiec.

OSHA Educational Materials

OSHA has many types of educational materials in English, Spanish, Vietnamese and other languages available in print or online. These include:

- Brochures/booklets;
- Fact Sheets;
- Guidance documents that provide detailed examinations of specific safety and health issues;
- Online Safety and Health Topics pages;
- Posters;
- Small, laminated QuickCards™ that provide brief safety and health information; and
- *QuickTakes*, OSHA's free, twice-monthly online newsletter with the latest news about OSHA initiatives and products to assist employers and workers in finding and preventing workplace hazards. To sign up for *QuickTakes* visit www.osha.gov/quicktakes.

To view materials available online or for a listing of free publications, visit www.osha.gov/publications. You can also call 1-800-321-OSHA (6742) to order publications.

Select OSHA publications are available in e-Book format. OSHA e-Books are designed to increase readability on smartphones, tablets and other mobile devices. For access, go to www.osha.gov/ebooks.

OSHA's web site also has information on job hazards and injury and illness prevention for employers and workers. To learn more about OSHA's safety and health resources online, visit www.osha.gov or www.osha.gov/html/a-z-index.html.

NIOSH Health Hazard Evaluation Program

Getting Help with Health Hazards

The National Institute for Occupational Safety and Health (NIOSH) is a federal agency that conducts scientific and medical research on workers' safety and health. At no cost to employers or workers, NIOSH can help identify health hazards and recommend ways to reduce or eliminate those hazards in the workplace through its Health Hazard Evaluation (HHE) Program.

Workers, union representatives and employers can request a NIOSH HHE. An HHE is often requested when there is a higher than expected rate of a disease or injury in a group of workers. These situations may be the result of an unknown cause, a new hazard, or a mixture of sources. To request a NIOSH Health Hazard Evaluation go to www.cdc.gov/niosh/hhe/request.html. To find out more, in English or Spanish, about the Health Hazard Evaluation Program:

E-mail HHERequestHelp@cdc.gov or call 800-CDC-INFO (800-232-4636).

OSHA Regional Offices

Region I
Boston Regional Office
(CT*, ME*, MA, NH, RI, VT*)
JFK Federal Building, Room E340
Boston, MA 02203
(617) 565-9860 (617) 565-9827 Fax

Region II
New York Regional Office
(NJ*, NY*, PR*, VI*)
201 Varick Street, Room 670
New York, NY 10014
(212) 337-2378 (212) 337-2371 Fax

Region III
Philadelphia Regional Office
(DE, DC, MD*, PA, VA*, WV)
The Curtis Center
170 S. Independence Mall West
Suite 740 West
Philadelphia, PA 19106-3309
(215) 861-4900 (215) 861-4904 Fax

Region IV
Atlanta Regional Office
(AL, FL, GA, KY*, MS, NC*, SC*, TN*)
61 Forsyth Street, SW, Room 6T50
Atlanta, GA 30303
(678) 237-0400 (678) 237-0447 Fax

Region V
Chicago Regional Office
(IL*, IN*, MI*, MN*, OH, WI)
230 South Dearborn Street
Room 3244
Chicago, IL 60604
(312) 353-2220 (312) 353-7774 Fax

Region VI
Dallas Regional Office
(AR, LA, NM*, OK, TX)
525 Griffin Street, Room 602
Dallas, TX 75202
(972) 850-4145 (972) 850-4149 Fax
(972) 850-4150 FSO Fax

Region VII
Kansas City Regional Office
(IA*, KS, MO, NE)
Two Pershing Square Building
2300 Main Street, Suite 1010
Kansas City, MO 64108-2416
(816) 283-8745 (816) 283-0547 Fax

Region VIII
Denver Regional Office
(CO, MT, ND, SD, UT*, WY*)
Cesar Chavez Memorial Building
1244 Speer Boulevard, Suite 551
Denver, CO 80204
(720) 264-6550 (720) 264-6585 Fax

Region IX
San Francisco Regional Office
(AZ*, CA*, HI*, NV*, and American Samoa,
Guam and the Northern Mariana Islands)
90 7th Street, Suite 18100
San Francisco, CA 94103
(415) 625-2547 (415) 625-2534 Fax

Region X
Seattle Regional Office
(AK*, ID, OR*, WA*)
300 Fifth Avenue, Suite 1280
Seattle, WA 98104
(206) 757-6700 (206) 757-6705 Fax

* These states and territories operate their own OSHA-approved job safety and health plans and cover state and local government employees as well as private sector employees. The Connecticut, Illinois, Maine, New Jersey, New York and Virgin Islands programs cover public employees only. (Private sector workers in these states are covered by Federal OSHA). States with approved programs must have standards that are identical to, or at least as effective as, the Federal OSHA standards.

Note: To get contact information for OSHA area offices, OSHA-approved state plans and OSHA consultation projects, please visit us online at www.osha.gov or call us at 1-800-321-OSHA (6742).

How to Contact OSHA

For questions or to get information or advice, to report an emergency, fatality, inpatient hospitalization, amputation, or loss of an eye, or to file a confidential complaint, contact your nearest OSHA office, visit www.osha.gov or call OSHA at 1-800-321-OSHA (6742), TTY 1-877-889-5627.

For assistance, contact us.
We are OSHA. We can help.

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R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 30, June 18, 2021

Workplace Violence Prevention Standards

Effective January 1, 2022, new and revised workplace violence prevention standards will apply to all Joint Commission-accredited hospitals and critical access hospitals. According to US Bureau of Labor Statistics data, the incidence of violence-related health care worker injuries has steadily increased for at least a decade. Incidence data reveal that in 2018 health care and social service workers were five times more likely to experience workplace violence than all other workers—comprising 73% of all nonfatal workplace injuries and illnesses requiring days away from work. However, workplace violence is underreported, indicating that the actual rates may be much higher. Exposure to workplace violence can impair effective patient care and lead to psychological distress, job dissatisfaction, absenteeism, high turnover, and higher costs.

The high incidence of workplace violence prompted the creation of new accreditation requirements. The new and revised Joint Commission standards provide a framework to guide hospitals in developing effective workplace violence prevention systems, including leadership oversight, policies and procedures, reporting systems, data collection and analysis, post-incident strategies, training, and education to decrease workplace violence.

The accreditation manual's Glossary now defines workplace violence as "An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors."

Engagement with stakeholders, customers, and experts

In addition to an extensive literature review and public field review, The Joint Commission sought expert guidance from the following groups:

- Technical Advisory Panel (TAP) of practicing clinicians from health care and academic organizations, professional associations, and healthcare and government sectors.
- Standards Review Panel (SRP) of representatives from organizations or professional associations who provided a "boots on the ground" point of view and insights into the practical application of the proposed standards.

The prepublication version of the workplace violence prevention standards will be available online until December 31, 2021. After January 1, 2022, please access the new requirements in the E-dition or standards manual.

Environment of Care

Standard EC.02.01.01: The hospital manages safety and security risks.

Requirement	**EP 17:** The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis. (See also EC.04.01.01, EP 1) Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.
Rationale	A successful approach to evaluating the effectiveness of a workplace violence prevention program requires the performance of a worksite analysis. Environmental modifications are then implemented based on findings from the analysis. With best practices and applicable laws and regulations constantly evolving, hospitals must also review the program's policies and procedures, training, and education for consistency with the latest recommendations.
Reference*	1. Arbury, S., Zankowski, D., Lipscomb, J. & Hodgson, M. (2017) Workplace violence training programs for health care workers: an analysis of program elements. *Workplace Health & Safety.* 65(6), 266-272. DOI: 10.1177/2165079916671534. 2. International Association for Healthcare Security and Safety Foundation Evidence Based Healthcare Security Research Committee. (2019) IAHSS-F RS-19-02-"Threat assessment strategies to mitigate violence in healthcare". https://iahssf.org/assets/IAHSS-Foundation-Threat-Assessment-Strategies-to-Mitigate-Violence-in-Healthcare.pdf 3. McPhaul, K.M., London, M. & Lipscomb, J.A. (2013) A framework for translating workplace violence intervention research into evidence-based programs. *The Online Journal of Issues in Nursing.* Volume 18. Published online 1/1/2013. Accessed 11/16/2020 from http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No1-Jan-2013/A-Framework-for-Evidence-Based-Programs.html?css=print 4. Occupational Safety and Health Administration, United States Department of Labor. (2016). "OSHA 3148-06R 2016: Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers." https://www.osha.gov/Publications/osha3148.pdf 5. The Joint Commission Division of Healthcare Improvement. (2019) Quick safety: de-escalation in health care. Issue 47.

Standard EC.04.01.01: The hospital collects information to monitor conditions in the environment.

Requirement	**EP 1:** The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following: - Injuries to patients or others within the hospital's facilities - Occupational illnesses and staff injuries - Incidents of damage to its property or the property of others - **Safety and** security incidents involving patients, staff, or others within its facilities, **including those related to workplace violence** - Hazardous materials and waste spills and exposures - Fire safety management problems, deficiencies, and failures - Medical or laboratory equipment management problems, failures, and use errors - Utility systems management problems, failures, or use errors *Cont.*

Requirement	*Cont.* Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions as well as to the designated leader of the workplace violence reduction effort. A summary of such incidents may also be shared with the person designated to coordinate safety management activities. Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process. (See also EC.02.01.01, EP 17) **EP 6:** Based on its process(es), the hospital reports and investigates the following: **Safety and** security incidents involving patients, staff, or others within its facilities, **including those related to workplace violence.**
Rationale	Establishing a process to collect data by monitoring, reporting, and investigating workplace violence incidents allows the hospital and critical access hospital to identify risk factors in the vulnerable areas and implement environmental controls, education, and other mitigation strategies. Ongoing data collection can identify trends, patterns, gaps in the program, and effectiveness of the program. Underreporting of workplace violence incidents is thought to be a major problem. As more organizations adopt standard processes for collecting and reporting data on workplace violence incidents, it should be possible to benchmark the performance of workplace violence prevention programs so hospitals can judge their effectiveness and make modifications to further reduce incidents.
Reference*	1. Arnetz, J.E., Hamblin, L., Essenmacher, L., Upfal, M.J., Ager, J. & Luborsky, M. (2015) Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports. *Journal of Advanced Nursing.* 71(2), 338-348. DOI: 10.1111/jan.12494. 2. Hills D.J., Ross H.M., Pich J., Hill A.T., Dalsbø T.K., Riahi S., Guay S., & Martínez-Jarreta B., (2015) Education and training for preventing and minimising workplace aggression directed toward healthcare workers. *Cochrane Database of Systematic Reviews.* Issue 9. DOI: 10.1002/14651858.CD011860. 3. McPhaul, K.M., London, M. & Lipscomb, J.A. (2013) A framework for translating workplace violence intervention research into evidence-based programs. The Online Journal of Issues in Nursing. Volume 18. Published online 1/1/2013. Accessed 11/16/2020 from http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No1-Jan-2013/A-Framework-for-Evidence-Based-Programs.html?css=print 4. Morphet, J., Griffiths, D. & Innes, K. (2018). The trouble with reporting and utilization of workplace violence data in health care. *Journal of Nursing Management.* 27; 592-598. DOI: 10.1111/jonm.12717 5. Occupational Safety and Health Administration, United States Department of Labor. (2016). "OSHA 3148-06R 2016: Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers." https://www.osha.gov/Publications/osha3148.pdf 6. Odes, R., Hong, O., Harrison, R. & Chapman, S. (2020) Factors associated with physical injury or police involvement during incidents of workplace violence in hospitals: findings from the first year of California's new standard. *American Journal of Industrial Medicine.* 1-7. DOI: 10.1002/ajim.23103.

Standard HR.01.05.03: Staff participate in ongoing education and training.

Requirement	**EP 29:** As part of its workplace violence prevention program, the hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leadership, staff, and licensed practitioners. The hospital determines what aspects of training are appropriate for individuals based on their roles and responsibilities. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows: - What constitutes workplace violence - Education on the roles and responsibilities of leadership, clinical staff, security personnel, and external law enforcement - Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents - The reporting process for workplace violence incidents
Rationale	Recognition of what constitutes workplace violence begins with awareness of the different types of physical and nonphysical acts and threats of workplace violence. Additionally, education and training should focus on de-escalation and intervention techniques when confronted with incidents of workplace violence. Incorporating violence prevention tools and encouraging the use of a simple and accessible reporting process can ultimately reduce the likelihood of health care staff being victims of workplace violence.
Reference*	1. Arbury, S., Zankowski, D., Lipscomb, J. & Hodgson, M. (2017) Workplace violence training programs for health care workers. Workplace Health & Safety. 65(6), 266-272. DOI: 10.1177/2165079916671534. 2. Boyle, M.J. & Wallis, J. (2016) Working towards a definition for workplace violence actions in the health sector. *Safety in Health.* 2(4), 1-6. DOI: 10.1186/s40886-016-0015-8 3. Martinez, A.J.S. (2016) Managing workplace violence with evidence-based interventions: A literature review. *Journal of Psychosocial Nursing.* 54(9), 31-36. DOI: 10.3928/02793695-20160817-05 4. Occupational Safety and Health Administration, United States Department of Labor. (2015). "Preventing workplace violence: A roadmap for healthcare facilities." https://www.osha.gov/Publications/OSHA3827.pdf 5. Shulman, A. (2020) Mitigating workplace violence via de-escalation training. International Association for Healthcare Security and Safety Foundation. IAHSS-F RS-20-01. 6. The Joint Commission Division of Healthcare Improvement. (2019) Quick Safety: de-escalation in health care. Issue 47.

Leadership

Standard LD.03.01.01: Leaders create and maintain a culture of safety and quality throughout the hospital.

Requirement	**EP 9:** The hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes the following: - Policies and procedures to prevent and respond to workplace violence - A process to report incidents in order to analyze incidents and trends - A process for follow up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary - Reporting of workplace violence incidents to the governing body

Rationale	Identifying an individual to be accountable for an organization's workplace violence prevention program establishes clear lines of accountability. Additionally, having policies and a standardized process to report and follow up on events or near-misses decreases variation in the program. Data collection and simple, accessible reporting structures show commitment to providing a safe and secure work environment. Regularly reporting incidents and trends to the governing body promotes transparency and further establishes accountability for the program.
Reference*	1. Arbury, S., Zankowski, D., Lipscomb, J. & Hodgson, M. (2017) Workplace violence training programs for health care workers: an analysis of program elements. *Workplace Health & Safety.* 65(6), 266-272. DOI: 10.1177/2165079916671534. 2. Arnetz, J.E., Hamblin, L., Ager, J., Aranyos, D., Essenmacher, L., Upfal, M.J. & Luborsky, M. (2015) Using database reports to reduce workplace violence: perceptions of hospital stakeholders. *Work.* 51(1), 51-59. DOI: 10.3233/WOR-141887. 3. Havaei, F., MacPhee, M., and Lee, S.E. (2018) The effect of violence prevention strategies on perceptions of workplace safety: A study of medical-surgical and mental health nurses. *Journal of Advanced Nursing.* 75, 1657-1666. DOI: 10.1111/jan.13950 4. McPhaul, K.M., London, M. & Lipscomb, J.A. (2013) A framework for translating workplace violence intervention research into evidence-based programs. *The Online Journal of Issues in Nursing.* 18(1), 1-13. DOI: 10.3912/OJIN.Vol18No01Man04. 5. Occupational Safety and Health Administration, United States Department of Labor. (2016). "OSHA 3148-06R 2016: Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers." https://www.osha.gov/Publications/osha3148.pdf 6. Odes, R., Hong, O., Harrison, R. & Chapman, S. (2020) Factors associated with physical injury or police involvement during incidents of workplace violence in hospitals: findings from the first year of California's new standard. *American Journal of Industrial Medicine.* 1-7. DOI: 10.1002/ajim.23103.

*Not a complete literature review.

Workplace Violence Prevention Advisory Rosters

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American Hospital Association™

Advancing Health in America

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March 23, 2022

The Honorable Merrick Garland
Attorney General
U.S. Department of Justice
950 Pennsylvania Ave. NW
Washington, DC 20530-0001

Dear Attorney General Garland:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) requests your support for legislation that would protect health care workers from assault and intimidation.

Hospitals and health systems have long had robust protocols in place to detect and deter violence against their team members. Since the onset of the pandemic, however, violence against hospital employees has markedly increased — and there is no sign it is receding. Studies indicate that 44% of nurses report experiencing physical violence and 68% report experiencing verbal abuse during the pandemic.[1]

News reports support these conclusions. To take just a few examples, a patient recently grabbed a nurse in Georgia by the wrist and kicked her in the ribs.[2] A nurse in South Dakota was thrown against a wall and bitten by a patient.[3] A medical student in New York who came from Thailand was called "China Virus," kicked, and dragged to the

[1] *E.g.*, Byon H, et al., Nurses' experience with Type II workplace violence and underreporting during the COVID-19 pandemic. *Workplace Health Saf.* 2021 21650799211031233.
[2] Shoshana Ungerleider and Sarah Warren, Nurses get spit on, kicked, assaulted. Stop hurting us. We are here to help you, *USA Today* (Jan. 10, 2022), https://www.usatoday.com/story/opinion/voices/2022/01/10/covid-nurses-assaulted-pandemic/9117731002/?gnt-cfr=1.
[3] Bart Pfankuch, Rising anger and violence toward health care workers hampering patient care in South Dakota, Argus Leader (Feb. 28, 2022), https://www.argusleader.com/story/news/2022/02/28/rising-anger-violence-toward-healthcare-workers-hurt-patient-care/6922874001/.

ground, leaving her hands bleeding and legs bruised.[4] The president of Mercy Health Saint Mary's in Michigan has reported: "Our staff are yelled at, punched, hit, scratched, we hear about these on a day-to-day basis."[5] And a Maine nurse has said: "We have been hit, bitten, choked, shoved, kicked, spit upon, and concussed."[6]

Workplace violence has severe consequences for the entire health care system. Not only does it cause physical and psychological injury for health care workers, but workplace violence and intimidation make it more difficult for nurses, doctors and other clinical staff to provide quality patient care. Nurses and doctors cannot provide attentive care when they are afraid for their personal safety, distracted by disruptive patients and family members, or traumatized from prior violent interactions. In addition, violent interactions at health care facilities tie up valuable resources and can delay urgently needed care for other patients. Studies show that workplace violence reduces patient satisfaction and employee productivity, and increases the potential for adverse medical events.

For medical professionals, being assaulted or intimidated can no longer be tolerated as "part of the job." This unacceptable situation demands a federal response.

Last year, you took decisive action to address the rise in violent behavior on commercial aircraft by directing United States Attorneys to prioritize prosecutions when airline employees were harmed by passengers. You wrote: "The Department of Justice is committed to using its resources to do its part to prevent violence, intimidation, threats of violence, and other criminal behavior that endangers the safety of passengers, flight crews, and flight attendants on commercial aircraft." As you recognized, vigorous enforcement creates a safe traveling environment, deters violent behavior, and ensures that offenders are appropriately punished.

Our nation's health care workers deserve the same protections and the same commitment from the Department of Justice. Unfortunately, there is no existing federal statute that protects health care workers from the even greater incidence of violence that they experience. **We therefore urge you to support legislation, modeled after 18 U.S.C. § 46504, that would provide similar protections as those that currently exist for flight crews and airport workers.**

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[4] Sydney Pereira, 'White Coats Don't Protect Us:' Asian Health Care Workers Speak Out Against Rise In Hate Crimes, *Gothamist* (Apr. 22, 2021), https://gothamist.com/news/white-coats-dont-protect-us-asian-health-care-workers-speak-out-against-rise-in-hate-crimes.

[5] Andrew Feather, Healthcare workers face increasing violence from patients amid COVID-19 surge, News Chanel 3 (Dec. 9. 2021), https://wwmt.com/news/local/healthcare-workers-face-increasing-violence-from-patients-amid-covid-19-surge.

[6] Chris Costa, Maine Medical Center ER nurses detail violent patient attacks, demand change, News Center Maine (Feb. 25, 2022), https://www.newscentermaine.com/article/news/health/emergency-room-nurses-demand-change-after-violent-conditions-at-maine-medical-center-portland/97-929dd8c5-2c5b-4901-a9d7-a138ac94cfa9.

From the day you took office as Attorney General, you have honored the Justice Department's obligation to protect the American people against violence and threats of violence. The AHA applauds your unwavering commitment to making our communities safer. We look forward to working with you to ensure that a key pillar of those communities — hospitals and health systems — can focus on caring for their patients without having to fear violence against their employees.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

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49 U.S.C.
United States Code, 2011 Edition
Title 49 - TRANSPORTATION
SUBTITLE VII - AVIATION PROGRAMS
PART A - AIR COMMERCE AND SAFETY
subpart iv - enforcement and penalties
CHAPTER 465 - SPECIAL AIRCRAFT JURISDICTION OF THE UNITED STATES
Sec. 46504 - Interference with flight crew members and attendants
From the U.S. Government Publishing Office, www.gpo.gov

§46504. Interference with flight crew members and attendants

An individual on an aircraft in the special aircraft jurisdiction of the United States who, by assaulting or intimidating a flight crew member or flight attendant of the aircraft, interferes with the performance of the duties of the member or attendant or lessens the ability of the member or attendant to perform those duties, or attempts or conspires to do such an act, shall be fined under title 18, imprisoned for not more than 20 years, or both. However, if a dangerous weapon is used in assaulting or intimidating the member or attendant, the individual shall be imprisoned for any term of years or for life.

(Pub. L. 103–272, §1(e), July 5, 1994, 108 Stat. 1244; Pub. L. 107–56, title VIII, §811(i), Oct. 26, 2001, 115 Stat. 382.)

Historical and Revision Notes

Revised Section	*Source (U.S. Code)*	*Source (Statutes at Large)*
46504	49 App.:1472(j).	Aug. 23, 1958, Pub. L. 85–726, 72 Stat. 731, §902(j); added Sept. 5, 1961, Pub. L. 87–197, §1, 75 Stat. 466; Oct. 14, 1970, Pub. L. 91–449, §1(3), 84 Stat. 921.

The words "or threatens" are omitted as being included in "intimidating". The words "(including any steward or stewardess)" are omitted as being included in "attendant". The words "fined under title 18" are substituted for "fined not more than $10,000" for consistency with title 18. The words "deadly or" are omitted as surplus.

AMENDMENTS

2001—Pub. L. 107–56 inserted "or attempts or conspires to do such an act," before "shall be fined under title 18,".

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117TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPT. 117–14
Part 1

WORKPLACE VIOLENCE PREVENTION FOR HEALTH CARE AND SOCIAL SERVICE WORKERS ACT

APRIL 5, 2021.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. SCOTT of Virginia, from the Committee on Education and Labor, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany H.R. 1195]

The Committee on Education and Labor, to whom was referred the bill (H.R. 1195) to direct the Secretary of Labor to issue an occupational safety and health standard that requires covered employers within the health care and social service industries to develop and implement a comprehensive workplace violence prevention plan, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

CONTENTS

19–006

The amendment is as follows:
Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Workplace Violence Prevention for Health Care and Social Service Workers Act".

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—WORKPLACE VIOLENCE PREVENTION STANDARD

SEC. 101. WORKPLACE VIOLENCE PREVENTION STANDARD.

(a) INTERIM FINAL STANDARD.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Labor shall issue an interim final standard on workplace violence prevention—

(A) to require certain employers in the health care and social service sectors, and certain employers in sectors that conduct activities similar to the activities in the health care and social service sectors, to develop and implement a comprehensive workplace violence prevention plan and carry out other activities or requirements described in section 103 to protect health care workers, social service workers, and other personnel from workplace violence; and

(B) that shall, at a minimum, be based on the Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers published by the Occupational Safety and Health Administration of the Department of Labor in 2015 and adhere to the requirements of this title.

(2) INAPPLICABLE PROVISIONS OF LAW AND EXECUTIVE ORDER.—The following provisions of law and Executive orders shall not apply to the issuance of the interim final standard under this subsection:

(A) The requirements applicable to occupational safety and health standards under section 6(b) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 655(b)).

(B) The requirements of chapters 5 and 6 of title 5, United States Code.

(C) Subchapter I of chapter 35 of title 44, United States Code (commonly referred to as the "Paperwork Reduction Act").

(D) Executive Order 12866 (58 Fed. Reg. 51735; relating to regulatory planning and review), as amended.

(3) NOTICE AND COMMENT.—Notwithstanding paragraph (2)(B), the Secretary shall, prior to issuing the interim final standard under this subsection, provide notice in the Federal Register of the interim final standard and a 30-day period for public comment.

(4) EFFECTIVE DATE OF INTERIM STANDARD.—The interim final standard shall—

(A) take effect on a date that is not later than 30 days after issuance, except that such interim final standard may include a reasonable phase-in period for the implementation of required engineering controls that take effect after such date;

(B) be enforced in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 655(b)); and

(C) be in effect until the final standard described in subsection (b) becomes effective and enforceable.

(5) FAILURE TO PROMULGATE.—If an interim final standard described in paragraph (1) is not issued not later than 1 year of the date of enactment of this Act, the provisions of this title shall be in effect and enforced in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act (29 U.S.C. 655(b)) until such provisions are superseded in whole by an interim final standard issued by the Secretary that meets the requirements of paragraph (1).

(b) FINAL STANDARD.—

(1) PROPOSED STANDARD.—Not later than 2 years after the date of enactment of this Act, the Secretary of Labor shall, pursuant to section 6 of the Occupational Safety and Health Act (29 U.S.C. 655), promulgate a proposed standard on workplace violence prevention—

(A) for the purposes described in subsection (a)(1)(A); and

(B) that shall include, at a minimum, requirements contained in the interim final standard promulgated under subsection (a).

(2) FINAL STANDARD.—Not later than 42 months after the date of enactment of this Act, the Secretary shall issue a final standard on such proposed standard that shall—

(A) provide no less protection than any workplace violence standard adopted by a State plan that has been approved by the Secretary under section 18 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 667), provided the Secretary finds that the final standard is feasible on the basis of the best available evidence; and

(B) be effective and enforceable in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 655(b)).

SEC. 102. SCOPE AND APPLICATION.

In this title:

(1) COVERED FACILITY.—

(A) IN GENERAL.—The term "covered facility" includes the following:

(i) Any hospital, including any specialty hospital, in-patient or outpatient setting, or clinic operating within a hospital license, or any setting that provides outpatient services.

(ii) Any residential treatment facility, including any nursing home, skilled nursing facility, hospice facility, and long-term care facility.

(iii) Any non-residential treatment or service setting.

(iv) Any medical treatment or social service setting or clinic at a correctional or detention facility.

(v) Any community care setting, including a community-based residential facility, group home, and mental health clinic.

(vi) Any psychiatric treatment facility.

(vii) Any drug abuse or substance use disorder treatment center.

(viii) Any independent freestanding emergency centers.

(ix) Any facility described in clauses (i) through (viii) operated by a Federal Government agency and required to comply with occupational safety and health standards pursuant to section 1960 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act).

(x) Any other facility the Secretary determines should be covered under the standards promulgated under section 101.

(B) EXCLUSION.—The term "covered facility" does not include an office of a physician, dentist, podiatrist, or any other health practitioner that is not physically located within a covered facility described in clauses (i) through (x) of subparagraph (A).

(2) COVERED SERVICES.—

(A) IN GENERAL.—The term "covered service" includes the following services and operations:

(i) Any services and operations provided in any field work setting, including home health care, home-based hospice, and home-based social work.

(ii) Any emergency services and transport, including such services provided by firefighters and emergency responders.

(iii) Any services described in clauses (i) and (ii) performed by a Federal Government agency and required to comply with occupational safety and health standards pursuant to section 1960 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act).

(iv) Any other services and operations the Secretary determines should be covered under the standards promulgated under section 101.

(B) EXCLUSION.—The term "covered service" does not include child day care services.

(3) COVERED EMPLOYER.—

(A) IN GENERAL.—The term "covered employer" includes a person (including a contractor, subcontractor, a temporary service firm, or an employee leasing entity) that employs an individual to work at a covered facility or to perform covered services.

(B) EXCLUSION.—The term "covered employer" does not include an individual who privately employs, in the individual's residence, a person to perform covered services for the individual or a family member of the individual.

(4) COVERED EMPLOYEE.—The term "covered employee" includes an individual employed by a covered employer to work at a covered facility or to perform covered services.

SEC. 103. REQUIREMENTS FOR WORKPLACE VIOLENCE PREVENTION STANDARD.

Each standard described in section 101 shall include, at a minimum, the following requirements:

(1) WORKPLACE VIOLENCE PREVENTION PLAN.—Not later than 6 months after the date of promulgation of the interim final standard under section 101(a), a covered employer shall develop, implement, and maintain an effective written workplace violence prevention plan (in this section referred to as the "Plan") for covered employees at each covered facility and for covered employees performing a covered service on behalf of such employer, which meets the following:

(A) PLAN DEVELOPMENT.—Each Plan shall—

(i) be developed and implemented with the meaningful participation of direct care employees, other employees, and employee representatives, for all aspects of the Plan;

(ii) be tailored and specific to conditions and hazards for the covered facility or the covered service, including patient-specific risk factors and risk factors specific to each work area or unit; and

(iii) be suitable for the size, complexity, and type of operations at the covered facility or for the covered service, and remain in effect at all times.

(B) PLAN CONTENT.—Each Plan shall include procedures and methods for the following:

(i) Identification of the individual and the individual's position responsible for implementation of the Plan.

(ii) With respect to each work area and unit at the covered facility or while covered employees are performing the covered service, risk assessment and identification of workplace violence risks and hazards to employees exposed to such risks and hazards (including environmental risk factors and patient-specific risk factors), which shall be—

(I) informed by past violent incidents specific to such covered facility or such covered service; and

(II) conducted with, at a minimum—

(aa) direct care employees;

(bb) where applicable, the representatives of such employees; and

(cc) the employer.

(iii) Hazard prevention, engineering controls, or work practice controls to correct hazards, in a timely manner, applying industrial hygiene principles of the hierarchy of controls, which—

(I) may include security and alarm systems, adequate exit routes, monitoring systems, barrier protection, established areas for patients and clients, lighting, entry procedures, staffing and working in teams, and systems to identify and flag clients with a history of violence; and

(II) shall ensure that employers correct, in a timely manner, hazards identified in any violent incident investigation described in paragraph (2) and any annual report described in paragraph (5).

(iv) Reporting, incident response, and post-incident investigation procedures, including procedures—

(I) for employees to report workplace violence risks, hazards, and incidents;

(II) for employers to respond to reports of workplace violence;

(III) for employers to perform a post-incident investigation and debriefing of all reports of workplace violence with the participation of employees and their representatives;

(IV) to provide medical care or first aid to affected employees; and

(V) to provide employees with information about available trauma and related counseling.

(v) Procedures for emergency response, including procedures for threats of mass casualties and procedures for incidents involving a firearm or a dangerous weapon.

(vi) Procedures for communicating with and training the covered employees on workplace violence hazards, threats, and work practice controls, the employer's plan, and procedures for confronting, responding to, and reporting workplace violence threats, incidents, and concerns, and employee rights.

(vii) Procedures for—

(I) ensuring the coordination of risk assessment efforts, Plan development, and implementation of the Plan with other employers who have employees who work at the covered facility or who are performing the covered service; and

(II) determining which covered employer or covered employers shall be responsible for implementing and complying with the provisions of the standard applicable to the working conditions over which such employers have control.

(viii) Procedures for conducting the annual evaluation under paragraph (6).

(C) AVAILABILITY OF PLAN.—Each Plan shall be made available at all times to the covered employees who are covered under such Plan.

(2) VIOLENT INCIDENT INVESTIGATION.—

(A) IN GENERAL.—As soon as practicable after a workplace violence incident, risk, or hazard of which a covered employer has knowledge, the employer shall conduct an investigation of such incident, risk, or hazard under which the employer shall—

(i) review the circumstances of the incident, risk, or hazard, and whether any controls or measures implemented pursuant to the Plan of the employer were effective; and

(ii) solicit input from involved employees, their representatives, and supervisors about the cause of the incident, risk, or hazard, and whether further corrective measures (including system-level factors) could have prevented the incident, risk, or hazard.

(B) DOCUMENTATION.—A covered employer shall document the findings, recommendations, and corrective measures taken for each investigation conducted under this paragraph.

(3) TRAINING AND EDUCATION.—With respect to the covered employees covered under a Plan of a covered employer, the employer shall provide training and education to such employees who may be exposed to workplace violence hazards and risks, which meet the following requirements:

(A) Annual training and education shall include information on the Plan, including identified workplace violence hazards, work practice control measures, reporting procedures, record keeping requirements, response procedures, anti-retaliation policies, and employee rights.

(B) Additional hazard recognition training shall be provided for supervisors and managers to ensure they—

(i) can recognize high-risk situations; and

(ii) do not assign employees to situations that predictably compromise the safety of such employees.

(C) Additional training shall be provided for each such covered employee whose job circumstances have changed, within a reasonable timeframe after such change.

(D) Applicable training shall be provided under this paragraph for each new covered employee prior to the employee's job assignment.

(E) All training shall provide such employees opportunities to ask questions, give feedback on training, and request additional instruction, clarification, or other followup.

(F) All training shall be provided in-person and by an individual with knowledge of workplace violence prevention and of the Plan, except that any annual training described in subparagraph (A) provided to an employee after the first year such training is provided to such employee may be conducted by live video if in-person training is impracticable.

(G) All training shall be appropriate in content and vocabulary to the language, educational level, and literacy of such covered employees.

(4) RECORDKEEPING AND ACCESS TO PLAN RECORDS.—

(A) IN GENERAL.—Each covered employer shall—

(i) maintain for not less than 5 years—

(I) records related to each Plan of the employer, including workplace violence risk and hazard assessments, and identification, evaluation, correction, and training procedures;

(II) a violent incident log described in subparagraph (B) for recording all workplace violence incidents; and

(III) records of all incident investigations as required under paragraph (2)(B); and

(ii)(I) make such records and logs available, upon request, to covered employees and their representatives for examination and copying in accordance with section 1910.1020 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act), and in a manner consistent with HIPAA privacy regulations (defined in section 1180(b)(3) of the Social Security Act (42 U.S.C. 1320d–9(b)(3))) and part 2 of title 42, Code of Federal Regulations (as such part is in effect on the date of enactment of this Act); and

(II) ensure that any such records and logs that may be copied, transmitted electronically, or otherwise removed from the employer's control for purposes of this clause omit any element of personal identifying information sufficient to allow identification of any patient, resident, client, or other individual alleged to have committed a violent incident (including the individual'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 such individual's identity).

(B) VIOLENT INCIDENT LOG DESCRIPTION.—Each violent incident log shall—

(i) be maintained by a covered employer for each covered facility controlled by the employer and for each covered service being performed by a covered employee on behalf of such employer;

(ii) be based on a template developed by the Secretary not later than 1 year after the date of enactment of this Act;

(iii) include, at a minimum, a description of—

(I) the violent incident (including environmental risk factors present at the time of the incident);

(II) the date, time, and location of the incident, and the names and job titles of involved employees;

(III) the nature and extent of injuries to covered employees;

(IV) a classification of the perpetrator who committed the violence, including whether the perpetrator was—

(aa) a patient, client, resident, or customer of a covered employer;

(bb) a family or friend of a patient, client, resident, or customer of a covered employer;

(cc) a stranger;

(dd) a coworker, supervisor, or manager of a covered employee;

(ee) a partner, spouse, parent, or relative of a covered employee; or

(ff) any other appropriate classification;

(V) the type of violent incident (such as type 1 violence, type 2 violence, type 3 violence, or type 4 violence); and

(VI) how the incident was abated;

(iv) not later than 7 days after the employer learns of such incident, contain a record of each violent incident, which is updated to ensure completeness of such record;

(v) be maintained for not less than 5 years; and

(vi) in the case of a violent incident involving a privacy concern case, protect the identity of employees in a manner consistent with section

1904.29(b) of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act).

(C) ANNUAL SUMMARY.—

(i) COVERED EMPLOYERS.—Each covered employer shall prepare and submit to the Secretary an annual summary of each violent incident log for the preceding calendar year that shall—

(I) with respect to each covered facility, and each covered service, for which such a log has been maintained, include—

(aa) the total number of violent incidents;

(bb) the number of recordable injuries related to such incidents; and

(cc) the total number of hours worked by the covered employees for such preceding year;

(II) be completed on a form provided by the Secretary;

(III) be posted for 3 months beginning February 1 of each year in a manner consistent with the requirements of section 1904 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act), relating to the posting of summaries of injury and illness logs;

(IV) be located in a conspicuous place or places where notices to employees are customarily posted; and

(V) not be altered, defaced, or covered by other material.

(ii) SECRETARY.—Not later than 1 year after the promulgation of the interim final standard under section 101(a), the Secretary shall make available a platform for the electronic submission of annual summaries required under this subparagraph.

(5) ANNUAL REPORT.—

(A) REPORT TO SECRETARY.—Not later than February 15 of each year, each covered employer shall report to the Secretary, on a form provided by the Secretary, the frequency, quantity, and severity of workplace violence, and any incident response and post-incident investigation (including abatement measures) for the incidents set forth in the annual summary of the violent incident log described in paragraph (4)(C). The contents of the report of the Secretary to Congress shall not disclose any confidential information.

(B) REPORT TO CONGRESS.—Not later than 6 months after February 15 of each year, the Secretary shall submit to Congress a summary of the reports received under subparagraph (A).

(6) ANNUAL EVALUATION.—Each covered employer shall conduct an annual written evaluation, conducted with the full, active participation of covered employees and employee representatives, of—

(A) the implementation and effectiveness of the Plan, including a review of the violent incident log; and

(B) compliance with training required by each standard described in section 101, and specified in the Plan.

(7) PLAN UPDATES.—Each covered employer shall incorporate changes to the Plan, in a manner consistent with paragraph (1)(A)(i) and based on findings from the most recent annual evaluation conducted under paragraph (6), as appropriate.

(8) ANTI-RETALIATION.—

(A) POLICY.—Each covered employer shall adopt a policy prohibiting any person (including an agent of the employer) from the discrimination or retaliation described in subparagraph (B).

(B) PROHIBITION.—No covered employer shall discriminate or retaliate against any employee for—

(i) reporting a workplace violence incident, threat, or concern to, or seeking assistance or intervention with respect to such incident, threat, or concern from, the employer, law enforcement, local emergency services, or a local, State, or Federal government agency; or

(ii) exercising any other rights under this paragraph.

(C) ENFORCEMENT.—This paragraph shall be enforced in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act (29 U.S.C. 655(b)).

SEC. 104. RULES OF CONSTRUCTION.

Notwithstanding section 18 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 667)—

(1) nothing in this title shall be construed to curtail or limit authority of the Secretary under any other provision of the law;

(2) the rights, privileges, or remedies of covered employees shall be in addition to the rights, privileges, or remedies provided under any Federal or State law, or any collective bargaining agreement; and

(3) nothing in this Act shall be construed to limit or prevent health care workers, social service workers, and other personnel from reporting violent incidents to appropriate law enforcement.

SEC. 105. OTHER DEFINITIONS.

In this title:

(1) WORKPLACE VIOLENCE.—

(A) IN GENERAL.—The term "workplace violence" means any act of violence or threat of violence, without regard to intent, that occurs at a covered facility or while a covered employee performs a covered service.

(B) EXCLUSIONS.—The term "workplace violence" does not include lawful acts of self-defense or lawful acts of defense of others.

(C) INCLUSIONS.—The term "workplace violence" includes—

(i) the threat or use of physical force against a covered employee that results in or has a high likelihood of resulting in injury, psychological trauma, or stress, without regard to whether the covered employee sustains an injury, psychological trauma, or stress; and

(ii) an incident involving the threat or use of a firearm or a dangerous weapon, including the use of common objects as weapons, without regard to whether the employee sustains an injury, psychological trauma, or stress.

(2) TYPE 1 VIOLENCE.—The term "type 1 violence"—

(A) means workplace violence directed at a covered employee at a covered facility or while performing a covered service by an individual who has no legitimate business at the covered facility or with respect to such covered service; and

(B) includes violent acts by any individual who enters the covered facility or worksite where a covered service is being performed with the intent to commit a crime.

(3) TYPE 2 VIOLENCE.—The term "type 2 violence" means workplace violence directed at a covered employee by customers, clients, patients, students, inmates, or any individual for whom a covered facility provides services or for whom the employee performs covered services.

(4) TYPE 3 VIOLENCE.—The term "type 3 violence" means workplace violence directed at a covered employee by a present or former employee, supervisor, or manager.

(5) TYPE 4 VIOLENCE.—The term "type 4 violence" means workplace violence directed at a covered employee by an individual who is not an employee, but has or is known to have had a personal relationship with such employee, or with a customer, client, patient, student, inmate, or any individual for whom a covered facility provides services or for whom the employee performs covered services.

(6) THREAT OF VIOLENCE.—The term "threat of violence" means a statement or conduct that—

(A) causes an individual to fear for such individual's safety because there is a reasonable possibility the individual might be physically injured; and

(B) serves no legitimate purpose.

(7) ALARM.—The term "alarm" means a mechanical, electrical, or electronic device that does not rely upon an employee's vocalization in order to alert others.

(8) DANGEROUS WEAPON.—The term "dangerous weapon" means an instrument capable of inflicting death or serious bodily injury, without regard to whether such instrument was designed for that purpose.

(9) ENGINEERING CONTROLS.—

(A) IN GENERAL.—The term "engineering controls" means an aspect of the built space or a device that removes a hazard from the workplace or creates a barrier between a covered employee and the hazard.

(B) INCLUSIONS.—For purposes of reducing workplace violence hazards, the term "engineering controls" includes electronic access controls to employee occupied areas, weapon detectors (installed or handheld), enclosed workstations with shatter-resistant glass, deep service counters, separate rooms or areas for high-risk patients, locks on doors, removing access to or securing items that could be used as weapons, furniture affixed to the floor, opaque glass in patient rooms (which protects privacy, but allows the health care provider to see where the patient is before entering the room), closed-

circuit television monitoring and video recording, sight-aids, and personal alarm devices.

(10) ENVIRONMENTAL RISK FACTORS.—

(A) IN GENERAL.—The term "environmental risk factors" means factors in the covered facility or area in which a covered service is performed that may contribute to the likelihood or severity of a workplace violence incident.

(B) CLARIFICATION.—Environmental risk factors may be associated with the specific task being performed or the work area, such as working in an isolated area, poor illumination or blocked visibility, and lack of physical barriers between individuals and persons at risk of committing workplace violence.

(11) PATIENT-SPECIFIC RISK FACTORS.—The term "patient-specific risk factors" means factors specific to a patient that may increase the likelihood or severity of a workplace violence incident, including—

(A) a patient's treatment and medication status, and history of violence and use of drugs or alcohol; and

(B) any conditions or disease processes of the patient that may cause the patient to experience confusion or disorientation, be non-responsive to instruction, behave unpredictably, or engage in disruptive, threatening, or violent behavior.

(12) SECRETARY.—The term "Secretary" means the Secretary of Labor.

(13) WORK PRACTICE CONTROLS.—

(A) IN GENERAL.—The term "work practice controls" means procedures and rules that are used to effectively reduce workplace violence hazards.

(B) INCLUSIONS.—The term "work practice controls" includes—

(i) assigning and placing sufficient numbers of staff to reduce patient-specific type 2 violence hazards;

(ii) provision of dedicated and available safety personnel such as security guards;

(iii) employee training on workplace violence prevention methods and techniques to de-escalate and minimize violent behavior; and

(iv) employee training on procedures for response in the event of a workplace violence incident and for post-incident response.

TITLE II—AMENDMENTS TO THE SOCIAL SECURITY ACT

SEC. 201. APPLICATION OF THE WORKPLACE VIOLENCE PREVENTION STANDARD TO CERTAIN FACILITIES RECEIVING MEDICARE FUNDS.

(a) IN GENERAL.—Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (X), by striking "and" at the end;

(B) in subparagraph (Y), by striking the period at the end and inserting "; and"; and

(C) by inserting after subparagraph (Y) the following new subparagraph:

"(Z) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act) and skilled nursing facilities that are not otherwise subject to such Act (or such a State occupational safety and health plan), to comply with the Workplace Violence Prevention Standard (as promulgated under section 101 of the Workplace Violence Prevention for Health Care and Social Service Workers Act).";

and

(2) in subsection (b)(4)—

(A) in subparagraph (A), by inserting "and a hospital or skilled nursing facility that fails to comply with the requirement of subsection (a)(1)(Z) (relating to the Workplace Violence Prevention Standard)" after "Bloodborne Pathogens standard)";

and

(B) in subparagraph (B)—

(i) by striking "(a)(1)(U)" and inserting "(a)(1)(V)";

and

(ii) by inserting "(or, in the case of a failure to comply with the requirement of subsection (a)(1)(Z), for a violation of the Workplace Violence Prevention standard referred to in such subsection by a hospital or skilled nursing facility, as applicable, that is subject to the provisions of such Act)" before the period at the end.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply beginning on the date that is 1 year after the date of issuance of the interim final standard on workplace violence prevention required under section 101.

PURPOSE AND SUMMARY

The purpose of H.R. 1195, the *Workplace Violence Prevention for Health Care and Social Service Workers Act*, is to direct the Occupational Safety and Health Administration (OSHA) to issue, within 42 months of the date of enactment, a federal workplace violence prevention standard to protect workers in the health care and social services sectors. H.R. 1195 also requires hospitals and skilled nursing facilities that receive Medicare funds and that are operated by state or local governments in states that are not subject to the jurisdiction of the Occupational Safety and Health Act of 1970 (OSH Act) or a state OSHA plan to comply with the workplace violence prevention standard to be issued by OSHA.

Health care and social service workers are at high risk of assault by patients, clients, and members of the public. Peer reviewed studies and Bureau of Labor Statistics (BLS) data show high injury rates from workplace violence for these workers.[1] BLS statistics indicate public employees are at even higher risk, but they are not covered by Federal or state OSHA in 24 states. Furthermore, assaults on health care and social service workers are underreported because reporting practices are burdensome; many health care and social service workers perceive such violence as part of their job; and, they are often disciplined for reporting assaults.[2]

Federal OSHA does not currently have an enforceable standard that requires employers to adopt or implement a workplace violence prevention program, and it typically takes OSHA decades to issue final standards absent congressional direction. Voluntary efforts alone have proven insufficient even though OSHA has issued and updated voluntary guidelines delineating best practices for preventing violence in health care and social service settings, and OSHA has provided employers with compliance assistance for over 20 years. Government statistics show the problem is growing in the health care and social service sectors.

H.R. 1195 would ensure that health care and social service workplaces adopt violence prevention plans to prevent or mitigate violent incidents in the workplace using proven prevention techniques tailored to the risks in a given workplace. An OSHA standard would strengthen protections for workers where employers are failing to take the appropriate protective measures or have no kind of plan to address the problem.

COMMITTEE ACTION

115TH CONGRESS

On March 8, 2018, Representative Ro Khanna (D–CA–17) introduced H.R. 5223, the *Health Care Workplace Violence Prevention Act*. The bill would have required OSHA to address workplace violence in health care facilities by issuing a workplace violence pre-

[1] Bureau of Labor Statistics, Survey of Occupational Injuries and Illnesses (2019), https://www.bls.gov/web/osh/cd_r8.htm.

[2] Sentinel Event Alert, Physical and Verbal Violence Against Health Care Workers 2 (2018), https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf.

vention standard within two years of enactment that would require certain health care employers to adopt a comprehensive plan for protecting workers and other personnel from workplace violence. The bill was referred to the Committee on Education and the Workforce as well as the Committees on Energy and Commerce and Ways and Means.

On November 16, 2018, Representative Joe Courtney (D–CT–2) introduced H.R. 7141, the *Workplace Violence Prevention for Health Care and Social Service Workers Act.* The bill directed OSHA to issue a workplace violence prevention standard that requires certain employers in the health care and social service sectors to develop and implement a comprehensive plan for protecting workers from workplace violence. H.R. 7141 directed OSHA to issue an interim final standard within one year of enactment, to propose a final standard within two years of enactment, and to issue a final standard within 42 months of the date of enactment. The bill notes that OSHA standard should, at a minimum, be based on the OSHA *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.* The bill was referred to the Committee on Education and the Workforce as well as the Committees on Energy and Commerce and Ways and Means.

116TH CONGRESS

On February 19, 2019, Representative Courtney introduced H.R. 1309, the *Workplace Violence Prevention for Health Care and Social Service Workers Act.*

The bill directed OSHA to issue a workplace violence prevention standard that requires certain employers in the health care and social service sectors to develop and implement a comprehensive plan for protecting workers from workplace violence. H.R. 1309 directed OSHA to issue an interim final standard within one year of enactment, to propose a final standard within two years of enactment, and to issue a final standard within 42 months of the date of enactment. The OSHA standard should, at a minimum, be based on the OSHA *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.*[3] The bill was referred to the Committee on Education and Labor, the Committee on Energy and Commerce, and the Committee on Ways and Means.

On February 27, 2019, the Workforce Protections Subcommittee of the Committee on Education and Labor held a legislative hearing entitled *"Caring for the Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence"* (2019 WP Subcommittee Hearing). The hearing assessed the severity of workplace violence, examined the steps taken by OSHA, and considered the merits of legislation requiring OSHA to issue a violence prevention standard compared with continued reliance on voluntary guidelines. The Subcommittee heard testimony on the hazards of workplace violence faced by health care and social service workers, successful strategies for addressing and mitigating the hazards, and how the provisions outlined in H.R. 1309 would make workplaces safer. Witnesses included Angelo McClain, PhD, LICSW, Chief Executive Officer, National Association of Social Workers; Pa-

[3] Occupational Safety and Health Administration, Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, 5, (2016), https://www.osha.gov/Publications/osha3148.pdf.

tricia Moon-Updike, RN, former Psychiatric RN in the Child and Adolescent Treatment Unit of the Behavioral Health Division of Milwaukee County, representing the American Federation of Teachers; Dr. Jane Lipscomb, an expert on workplace violence; and Manesh K. Rath, a partner at the law firm Keller and Heckman.

On March 14, 2019, Senator Tammy Baldwin (D–WI) introduced S. 851, the *Workplace Violence Prevention for Health Care and Social Service Workers Act*, which was the Senate companion to H.R. 1309. S. 851 directed OSHA to issue an occupational safety and health standard that requires covered employers within the health care and social service industries to develop and implement a comprehensive workplace violence prevention plan. The bill was referred to the Senate Committee on Health, Education, Labor and Pensions.

On June 11, 2019, the House Committee on Education and Labor met for a full committee markup of H.R. 1309, the *Workplace Violence Prevention for Health Care and Social Service Workers Act*, and reported it favorably, as amended, to the House of Representatives by a vote of 26 ayes and 18 nays.

The Committee on Education and Labor considered the following amendments to H.R. 1309:

(1) An amendment in the nature of a substitute (ANS) was offered by Representative Courtney. The ANS incorporated the provisions of H.R. 1309 with the following modifications:

- established procedures for determining which covered employer or employers have responsibility for implementing and complying with the provisions of the standard in workplaces with multiple employers;
- excluded disclosure of "a patient's psychiatric condition" as part of reviewing "patient-specific risk factors" to better protect the confidential information of patients;
- allowed annual refresher training conducted by live video conferencing if in-person training is impracticable; and
- made technical corrections to ensure that congressional intent is clear.

(2) An amendment was offered by Representative Haley Stevens (D–MI–11) that required OSHA to provide a 30-day public comment period prior to the issuance of an interim final standard. The amendment was adopted by a voice vote.

(3) A substitute amendment to the ANS was offered by Representative Bradley Byrne (R–AL–1). Amongst its provisions, the amendment required OSHA to issue a final workplace violence prevention standard; however, it failed to: include any deadline for issuance of a final standard; require the issuance of an interim final standard prior to issuance of a final standard; require that an annual summary of violent incidents be transmitted to OSHA; include language prohibiting employers from retaliating against an employee for reporting a workplace violence incident or for seeking assistance or intervention from the employer, law enforcement, emergency services, or a state or local agency; and provide OSHA with authority to administratively enforce, and order abatement of an employer's violations of the anti-retaliation standard. In other words, it effectively removed any of the teeth that the base bill included. The amendment was rejected by a vote of 20 yeas and 25 nays.

(4) The ANS, as amended, was adopted by voice vote, and the bill, as amended, was reported favorably to the House by a vote of 26 ayes and 18 nays.

H.R. 1309 was passed by the House on November 18, 2019 by a vote of 251 yeas and 158 nays.

117TH CONGRESS

On March 11, 2021, Representative Courtney introduced H.R. 1195, the *Workplace Violence Prevention for Health Care and Social Service Workers Act.* It currently has 125 cosponsors: 120 Democrats and 5 Republicans.

The bill directs OSHA to issue a workplace violence prevention standard that requires certain employers in the health care and social service sectors to develop and implement a comprehensive plan for protecting workers from workplace violence. H.R. 1195 directs OSHA to issue an interim final standard within one year of enactment, to propose a final standard within two years of enactment, and to issue a final standard within 42 months of the date of enactment. The OSHA standard should, at a minimum, be based on the OSHA *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (Guidelines.)*[4] The bill was referred to the Committee on Education and Labor as well as the Committees on Energy and Commerce and Ways and Means.

H.R. 1195 is substantially similar to H.R. 1309 as passed in the House in the 116th Congress. Changes to H.R. 1195, as introduced, include the removal of a provision added during floor consideration of H.R. 1309 dealing with compliance assistance and a provision regarding training for victims of torture, trafficking, and domestic violence.

On March 11, 2021, the Subcommittee on Workforce Protections held a hearing entitled "Clearing the Air: Science Based Strategies to Protect Workers from COVID–19 Infections" (2021 WP Subcommittee Hearing). With regard to H.R. 1195, the Subcommittee heard testimony from Pascaline Muhindura, a nurse at Research Medical Center, Kansas City, MO, who described the hazards nurses in her hospital face from workplace violence, and the former Assistant Secretary for OSHA, Dr. David Michaels, who discussed the decades it often takes OSHA to issue a new standard.

On March 24, 2021, the House Committee on Education and Labor met for a full committee markup of H.R. 1195, the *Workplace Violence Prevention for Health Care and Social Service Workers Act*, and reported it favorably, as amended, to the House of Representatives by a vote of 27 ayes and 20 nays.

The Committee on Education and Labor considered the following amendments to H.R. 1195:

(1) An amendment in the nature of a substitute (ANS) was offered by Representative Courtney. The ANS incorporates the provisions of H.R. 1195 with the following modifications:

- Exempts the Interim Final Standard from Executive Order 12866, related to regulatory planning and review; and

[4] Occupational Safety and Health Administration, Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, 5 (2016), https://www.osha.gov/Publications/osha3148.pdf.

- Conditions the requirement that OSHA's final standard is no less protective than a state OSHA plan standard on the Secretary's finding that a state's requirements are feasible.

(2) A substitute amendment to the ANS was offered by Representative Tim Walberg (R–MI–7). Amongst its provisions, the amendment requires OSHA to issue a final workplace violence prevention standard, however, it fails to: include any deadline; precede the final standard with an interim final standard; require that an annual summary of violent incidents be transmitted to OSHA; include language prohibiting employers from retaliating against an employee for reporting a workplace violence incident or for seeking assistance or intervention from the employer, law enforcement, emergency services, or a state or local agency; and order abatement of an employer's violations of the anti-retaliation standard. As with the Republican ANS offered in the 116th Congress, it effectively removes any of the teeth that the base bill included. The amendment was rejected by a vote of 20 yeas and 27 nays.

(3) The ANS was adopted by voice vote, and the bill, as amended, was reported favorably to the House by a vote of 27 yeas and 20 nays.

COMMITTEE VIEWS

The Committee on Education and Labor (Committee) is committed to protecting the health and safety of our nation's workers. According to a 2016 Government Accountability Office (GAO) report entitled *Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence*, workplace violence is a serious concern for 15 million health care workers in the United States.[5] Although health care facilities are viewed as a place to get well, the reality is that day-to-day work in these facilities exposes many employees to an unacceptably high risk of violent injury—originating in almost all cases from patients, clients and residents. Federal injury data shows that the rates of workplace violence at health care facilities are high and rising. At state-run nursing and residential care facilities, the rates of serious injuries are higher than those in steel foundries, coal mines, hog farms or state prisons. OSHA does not require employers to have workplace violence prevention programs, but several states have enacted laws to better protect health care workers. Following the aforementioned GAO report and petitions for rulemaking, OSHA started work on an enforceable violence prevention standard at the end of the Obama Administration. However, all progress on a workplace violence prevention standard ceased during the four-year period between January 2017 and January 2021.

H.R. 1195, the *Workplace Violence Prevention for Health Care and Social Service Workers Act*, was introduced to require OSHA to issue an interim final standard within one year, to issue a workplace violence prevention standard within 42 months of the date of enactment, and to specify the main elements that must be included in an OSHA standard.

[5] United States Government Accountability Office, Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence (2016), https://www.gao.gov/assets/680/675858.pdf.

H.R. 1195 has been endorsed by: the AFL–CIO; American Federation of State; County and Municipal Employees; American Federation of Government Employees; American Federation of Teachers; American Industrial Hygiene Association; Alliance for Retired Americans; American Association for Psychoanalysis in Clinical Social Work; American College of Emergency Physicians; American College of Occupational and Environmental Medicine; American Counseling Association; American Nurses Association; American Psychiatric Association; American Public Health Association; American Society of Radiologic Technologists; American Society of Safety Professionals; Association of Women's Health; Obstetric and Neonatal Nurses; Coalition of Labor Union Women; Emergency Nurses Association; International Association of Fire Fighters; International Association of Forensic Nurses; International Association of Machinists and Aerospace Workers; Midstate Council for Occupational Safety and Health; National Association of Emergency Medical Technicians; National Association of Social Workers; National Nurses United; Philadelphia Area Project on Occupational Safety and Health; Public Citizen; Service Employees International Union; United Auto Workers; United Steelworkers; and Worksafe.

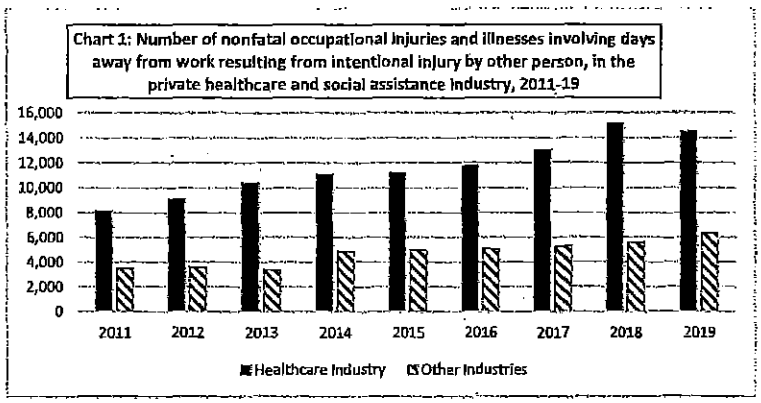
Health Care and Social Service Workers Are Paying the Price of Inaction

According to the BLS, in 2019, hospital workers were nearly five times as likely to suffer a serious workplace violence injury than all other workers, while workers in psychiatric hospitals are at 34 times greater risk of workplace violence injuries compared with all other workers.[6] BLS reports 20,870 health and social service workers had injuries so severe they lost workdays from injuries due to workplace violence in 2019, amounting to 70 percent of all workplace violence injuries across all industries.[7] The total number of the most severe workplace violence injuries in the health care and social service industry, which are those requiring days away from work, has nearly doubled since 2011 (see Chart 1).[8]

[6] Bureau of Labor Statistics, Survey of Occupational Injuries and Illnesses (2019), https://www.bls.gov/web/osh/cd_r8.htm (incidence rates of violence for nonfatal occupational injuries and illnesses involving days away from work).

[7] Bureau of Labor Statistics, Survey of Occupational Injuries and Illnesses (2019), https://www.bls.gov/iif/oshwc/osh/case/cd_r4_2019.htm (number of nonfatal occupational injuries and illnesses involving days away from work by industry and selected events or exposures leading to injury or illness, private industry).

[8] Bureau of Labor Statistics, Survey of Occupational Injuries and Illnesses (2019), generated from online database of "Nonfatal cases involving days away from work: selected characteristics (2011 forward)," https://www.bls.gov/iif/data.htm. See Appendix A attached to this Committee Report.



Several categories of health care and social service workers suffer especially high risk of workplace violence. While the overall rate of workplace assault-related injuries for private sector general industry workers was 4.4 per 10,000 in 2019, the workplace violence injury rate per 10,000 for licensed practical and vocational nurses was 16.4, registered nurses 14, social workers 16.1, nursing assistants 45.5, and psychiatric aides 247.2.[9]

Studies have found between 19–30 percent of hospital workers report being physically assaulted at work, and 70 percent of psychiatric hospital workers reported being assaulted during the past year.[10]

Emergency rooms are also high-risk workplaces. According to a 2018 survey conducted by American College of Emergency Physicians, nearly half of emergency physicians polled reported being physically assaulted, with more than 60 percent of those occurring within the past year. Nearly 7 in 10 emergency physicians say emergency department violence has increased within the past 5 years.[11]

The Cleveland Clinic has been forced to take action against violence in their emergency rooms:

> When you visit the Cleveland Clinic emergency department these days—whether as a patient, family member or friend—a large sign directs you toward a metal detector. An officer inspects all bags and then instructs you to walk through the metal detector. In some cases, a metal wand is used—even on patients who come in on stretchers. Cleveland Clinic officials say they confiscate thousands of weapons like knives, pepper spray and guns each year.

[9] Bureau of Labor Statistics, Survey of Occupational Injuries and Illnesses (2019), https://www.bls.gov/web/osh/cd_r100.htm (incidence rates of violence for nonfatal occupational injuries and illnesses involving days away from work).

[10] United States Government Accountability Office, Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence 12 (2016), https://www.gao.gov/assets/680/675858.pdf.

[11] Letter from American College of Emergency Physicians President Vidor Friedman to Representative Joe Courtney (Mar. 28, 2019), https://www.acep.org/globalassets/new-pdfs/advocacy/acep—workplace-violence-prevention-letter-of-support.pdf.

> The metal detectors were installed in response to what CEO Tom Mihaljevic is calling an epidemic.[12]

The problem of workplace violence against health care workers is getting worse. According to BLS statistics, from 2008 to 2019, the incidence rate for injuries resulting from workplace violence in psychiatric and substance abuse hospitals increased by 117 percent. The rate more than doubled in private hospitals, increased in home health care services by 58 percent, and increased by 55 percent in nursing and residential care facilities, while the overall rate for private sector health care and social service workers went up 69 percent over the same period.[13]

Pascaline Muhindura, a nurse at Research Medical Center, Kansas City, MO, testified at the 2021 WP Subcommittee Hearing that during the COVID–19 pandemic:

> The frequency of violent incidents in the workplace has increased. [National Nurses United's] most recent survey also found that workplace violence has been increasing during the pandemic—about 22% of hospital RNs reported a slight or substantial increase in workplace violence during the pandemic.[14]

The National Nurses United survey attribute the increase in workplace violence during the COVID pandemic on decreased staffing levels, changes in patient population, visitor restrictions (including visitors refusing to adhere to universal masking policies), increased wait times, and untreated conditions after loss of insurance, which lead to agitation, disorientation, or combativeness.[15]

Dr. Angelo McClain, Executive Director of the National Association of Social Workers, testified at the 2019 WP Subcommittee Hearing that social workers are also seeing increasing numbers of assaults:

> We are seeing more violence as there is more substance use and more critical kind of situations we are going into and we know with the opioid crisis, child welfare removals have gone up 20 percent.
>
> So, it's just working in those environments there's more opportunity or more tendency to confront violence situations.[16]

Workplace violence against this nation's caregivers not only causes serious physical injuries and sometimes death, but it can also lead to post-traumatic stress disorder (PTSD). Patricia Moon Updike, who testified at the 2019 WP Subcommittee Hearing, was

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[12] Marlene Harris-Taylor, *Facing Escalating Workplace Violence, Hospital Employees Have Had Enough*, National Public Radio (Apr. 8, 2019, 4:26 PM), https://www.npr.org/sections/health-shots/2019/04/08/709470502/facing-escalating-workplace-violence-hospitals-employees-have-had-enough.

[13] U.S. Department of Labor, Bureau of Labor Statistics, Survey of Occupational Injuries and Illnesses (2008), https://www.bls.gov/iif/oshwc/osh/case/ostb2090.pdf, (2010), https://www.bls.gov/web/osh/cd_r8.htm (incidence rates of violence for nonfatal occupational injuries and illnesses involving days away from work).

[14] *Clearing the Air: Science Based Strategies to Protect Workers from COVID–19 Infections, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. and Labor*, 117th Cong. (2021) (Written testimony of Pascaline Muhindura at 6).

[15] National Nurses United, Injury to None Preventing Workplace Violence to Protect Health Care Workers and Their Patients (Feb. 2021).

[16] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence*, YouTube (Mar. 1, 2019), https://www.youtube.com/watch?v=3B9eMBSBKm0 (question and answer between Rep. Courtney and McClain at 1:21:37).

assaulted by a patient in 2015 while working as a nurse in the Behavioral Health Division of Milwaukee County in the Child and Adolescent Treatment Unit. Not only did she suffer serious physical injuries, but also PTSD. She testified:

> I woke up after surgery with a large collar around my neck and I was fortunate. I was in pain. I was bruised and I was in shock, but my trachea was intact and I was breathing on my own.
>
> Two days later the nightmares started. I couldn't sleep. I figured it would pass. However, this was a different kind of feeling than I had ever experienced before. As time passed, I became more scared of people and children being unpredictable.
>
> Since this injury in 2015, I have been diagnosed with moderate to severe PTSD, moderate anxiety, insomnia, depressive disorder and social phobia related to this incident. I suffer from terrible memory problems. I cannot wear a seat belt properly, it comes too close to my neck and I have to wear it around my waist. I have not been to a mall, a concert or a sporting event since this assault due to my fear of crowds.[17]

Workplace Violence is More Severe in State and Local Government Health Care and Social Service Settings

In 2017, state government health care and social service workers were almost 9 times more likely to be injured by an assault than private sector health care workers (128.9 vs. 14.7 per 10,000 workers). Each year, nearly 7 percent of psychiatric aides employed in state and local government mental health facilities experienced violence-related injuries causing them to lose time from work. State psychiatric aides suffered an extraordinarily high rate of assault-related injuries in 2019—1,460.1 per 10,000 workers. State mental health and substance abuse social workers averaged 155 per 10,000 workers over the past five years; psychiatric technicians are at 429.6 per 10,000 workers; nursing, psychiatric and home health aides at 412.8 per 10,000 workers; health care support occupations at 506.6 per 10,000 workers; and nursing assistants at 132.1 per 10,000 workers.[18]

In 24 states, nearly 8 million workers employed by state and local governments[19] are not covered by Federal or state OSHA plans, and thus have no legal right to a safe workplace.[20] Under Section 3(b) of the OSH Act, OSHA may not enforce its standards

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[17] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. and Labor*, 116th Cong. (2019) (Written testimony of Patricia Moon-Updike at 3) [Hereinafter Moon-Updike Testimony].

[18] Bureau of Labor Statistics, Survey of Occupational Injuries and Illnesses (2019), generated from online database of "Nonfatal cases involving days away from work: selected characteristics (2011 forward)," https://www.bls.gov/iif/data.htm. See Appendix A attached to this Committee Report.

[19] Death on the Job: The Toll of Neglect, AFL–CIO, 23, (2019), https://aflcio.org/reports/death-job-toll-neglect-2019.

[20] Alabama, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Kansas, Louisiana, Massachusetts, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Texas, West Virginia, Wisconsin.

with respect to state and local government employers in those 24 states.[21]

In the 2019 WP Subcommittee Hearing, Patricia Moon-Updike testified about the predicament that public employees face without OSHA protections:

> There was no state agency responsible for protecting workers at my facility and that is still the case today. Workers were and are still getting hurt—and no one knows about it.
>
> There are no safety protocols in place and the employer has no incentive to implement them, or even record assaults. How can health care employees trust that a self-governing, bottom-line obsessed, patient satisfaction-oriented facility has the employees' lives as a priority if not directly being overseen by OSHA to do so?
>
> All workers deserve workplace safety protection. State and local public employees do some very difficult and dangerous jobs, including working in jails and prisons and caring for forensic patients (persons found unfit to be tried for a crime or found not guilty due to mental illness) in state psychiatric hospitals. These workers face risks that are generally not found in the private sector. They deserve protection from OSHA.[22]

Episodes of Workplace Violence of all Categories are Underreported and Workers Fear Retaliation for Reporting

Despite the BLS data showing a high rate of injuries to health care and social service workers from workplace violence, studies indicate these numbers are likely to represent a significant undercount of injuries resulting from assaults. According to the GAO, estimates of the percentage of injury cases that are formally reported ranged from 7 to 42 percent. Only 30 percent of nurses report incidents of workplace violence after being assaulted.[23] Among emergency department nurses, the reporting rate is 35 percent[24] and among emergency department physicians, the reporting rate is only 26 percent.[25] Other reports have found overall underreporting as high as 88 percent.[26]

Underreporting is due in part to thinking that enduring violence is "part of the job."[27] Moreover, workers often do not report injuries to employers because the reporting mechanism is burdensome, management discourages reporting, or they fear they will be

[21] 29 U.S.C. § 652 (5) states: "The term 'employer' means a person engaged in a business affecting commerce who has employees, but does not include the United States (not including the United States Postal Service) or any State or political subdivision of a State."

[22] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. and Labor*, 116th Cong. (2019) (forthcoming Moon-Updike response to a question for the record from Rep. Alma Adams).

[23] Judith E. Arnetz, et. al., *Underreporting of Workplace Violence: Comparison of Self-Report and Actual Documentation of Hospital Incidents*, 63 Workplace Health and Safety 207 (2015).

[24] Emergency Nurses Association Institute for Emergency Nursing Research, *Emergency Department Violence Surveillance Study*, 25 (Nov. 2011).

[25] M. Benham, et al., *Violence in the Emergency Department: A National Survey of Emergency Medicine Residents and Attending Physicians*, 40 Journal of Emergency Medicine 565, 568 (2011).

[26] Judith E. Arnetz, et. al., *Underreporting of Workplace Violence: Comparison of Self-Report and Actual Documentation of Hospital Incidents*, 63 Workplace Health and Safety 208 (2015).

[27] Sentinel Event Alert, Physical and Verbal Violence Against Health Care Workers, 2 (2018), https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf.

blamed for an altercation involving a patient or resident. Other reasons include inconvenience, fear of retaliation, unclear reporting policies, and expectation that nothing will be done.[28] Sometimes workers are uncertain what constitutes violence, because they often believe that their assailants are not responsible for their actions due to medical conditions. Some employers discourage reporting if they believe it will increase workers' compensation insurance rates.[29]

Ms. Moon-Updike confirmed these problems in her testimony at the 2019 WP Subcommittee Hearing:

> I don't know how many of the general public are aware that there is a code of silence in the nursing profession that you don't report. It is highly underreported the injuries in the nursing profession. It is, and excuse my vernacular, but it is pretty much suck it up and take it.[30]

Some nurses describe being blamed for altercations. According to an interview with Michelle Mahon, RN, a Nursing Practice Representative of National Nurses United:

> "What happens if they do report it?" she says. "In some cases, unfortunately, they are treated as if they are the ones who don't know how to do their job. Or that it's their fault that this happened."
>
> "There's a lot of focus on de-escalation techniques," Mahon adds. "Those are helpful tools, but oftentimes they are used to blame workers."[31]

And Ms. Moon-Updike confirmed the problem of retaliation in her testimony:

> it is not—it is not very well tolerated to report when you have been injured because often it falls back onto you as it was your fault for not being careful enough or using a protocol.[32]

The violent incident log, required under H.R. 1195, would address the problem of underreporting. As Dr. Jane Lipscomb stated in response to a Question for the Record following the 2019 WP Subcommittee Hearing:

> A required violent incident log would reduce the well-recognized problem of underreporting of incidents of workplace violence. A more complete reporting and analysis of incidents of workplace violence would allow health care organizations to understand the magnitude of the problem in their workplace and identify risk factors for violence that

[28] Karen Gabel Speroni, et al., *Incidence and Cost of Nurse Workplace Violence Perpetrated by Hospital Patients or Patient Visitors*, 41 Journal of Emergency Nursing 218, 227 (2014).

[29] Darryl Beard and Michelle Conley, Operation Safe Workplace: A Multidisciplinary Approach to Workplace Violence 11 (2017), https://www.jointcommission.org/assets/1/6/Aria_Workplace_Safety.pdf.

[30] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence*, YouTube (Mar. 1, 2019), https://www.youtube.com/watch?v=3B9eMBSBKm0 (question and answer between Rep. Jayapal and Moon-Updike at 00:54:46).

[31] Marlene Harris-Taylor, *Facing Escalating Workplace Violence, Hospital Employees Have Had Enough*, National Public Radio (Apr. 8, 2019), https://www.npr.org/sections/health-shots/2019/04/08/709470502/facing-escalating-workplace-violence-hospitals-employees-have-had-enough.

[32] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence*, YouTube (Mar. 1, 2019), https://www.youtube.com/watch?v=3B9eMBSBKm0 (question and answer between Rep. Jayapal and Moon-Updike at 00:55:22).

could then be prevented by the implementation of appropriate hazard controls.[33]

Workplace Violence in Health Care and Social Service Settings is Predictable and Preventable

Health care and social service workers face an elevated risk of work-related assaults, which results primarily from the violent behavior of their patients, clients, residents (or family members accompanying them). While no specific diagnosis or type of patient predicts specific incidents of future violence, studies consistently demonstrate that inpatient and acute psychiatric services, geriatric long-term care settings, high volume urban emergency departments, and residential and day social services present the highest risks. A prior history of violent behavior will also raise the likelihood that a patient or client will behave violently. Pain, devastating prognoses, long waiting times, unfamiliar surroundings, altered mental status associated with dementia, delirium or mind- and mood-altering medications and drugs, and disease progression can cause agitation and violent behaviors in patients, clients, or residents.[34]

Workplace violence traditionally falls into four types: Type 1 involves criminal intent, such as an assault in connection with a robbery; Type 2 involves clients, patients, or residents; Type 3 involves a coworker; and Type 4 is perpetrated by someone who knows or has a personal relationship with an employee at a workplace.[35] OSHA's *Guidelines* and a number of academic studies have identified workplace violence prevention plans as an effective tool to reduce or mitigate injuries from workplace violence—especially violence involving clients, patients or residents. Unlike some forms of violence, Type 2 violence can be anticipated and managed.

A workplace violence prevention plan requires risk assessment, implementation of controls, training, recordkeeping, and program evaluation. Controls may include engineering controls or administrative (work practice) controls. Engineering controls may include enhanced security and alarms, panic buttons, better exit routes, and better lighting. Administrative, or work practice controls, affect the way employees perform their job responsibilities and may include such measures as reducing crowding and waiting time, additional staffing, and implementing emergency response procedures.

While it is not the role of OSHA to dictate standards of care in health care settings, the voluntary OSHA *Guidelines* recommend the use of Trauma Informed Care (TIC) as a treatment technique and work practice control that has reduced violence in psychiatric

[33] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. and Labor*, 116th Cong. (2019) (forthcoming Lipscomb response to a question for the record from Rep. Alma Adams).

[34] Occupational Safety and Health Administration, Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, 5 (2016), https://www.osha.gov/Publications/osha3148.pdf.

[35] Occupational Safety and Health Administration, U.S. Department of Labor Directive CPL 02–01–058, Enforcement Procedures and Scheduling for Occupational Exposure to Workplace Violence (2017), https://www.osha.gov/OshDoc/Directive_pdf/CPL_02-01-058.pdf.

settings.[36] TIC is an intervention that recognizes that a patient or client's history of trauma may impact their response to services.[37]

Training may also help mitigate or prevent assaults. For example, training in de-escalation techniques has been shown to be effective.[38]

The Joint Commission, which accredits health care institutions, recommends:

> After a review of all pertinent data relating to workplace violence, develop evidence-based initiatives and interventions (when possible) to prevent and control workplace violence. Tailor specific interventions to problems identified at the local level.[39]

Many of the Joint Commission's recommended measures are included in H.R. 1195. These include the implementation of engineering and administrative controls, worker training and program evaluation, reporting systems, incident investigations, and protection against retaliation for reporting incidents.

Studies have shown that the measures in H.R. 1195 would significantly reduce assaults on health care and social service workers. Aria-Jefferson Health in Pennsylvania implemented many of the measures required by this standard and reduced violence-related injuries by 55 percent over three years.[40]

A recent randomized controlled trial involving seven hospitals in the Wayne State system compared 21 health care facility units that conducted workplace violence prevention techniques to units in 20 health care facility units that did not. The study found that six months post-intervention, incident rate ratios of violent events were significantly lower (more than a 50 percent reduction) on intervention units compared with controls. At the 24 month-follow up, the risk for violence-related injury was significantly lower (more than a 60 percent reduction) on intervention units compared with controls.[41] The types of intervention included a combination of environmental, administrative, and behavioral strategies. The intervention strategies used across study units were the exact type of interventions contained in OSHA's *Guidelines* and that would be required of employers by the OSHA standard required by H.R. 1195.

Dr. McClain testified at the 2019 WP Subcommittee Hearing that H.R. 1309 would also improve safety for social service workers who work in the field, and it would not require residents to make changes to their homes:

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[36] *Id.* at 7.

[37] Substance Abuse and Mental Health Services Administration, Trauma-Informed Care in Behavioral Health Services xix (2014), https://store.samhsa.gov/system/files/sma14-4816.pdf.

[38] Judith E. Arnetz, et al., *Preventing Patient-to-Worker Violence in Hospitals: Outcome of a Randomized Controlled Intervention*, 59 Journal of Occupational and Environmental Medicine 18 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5214512/pdf/nihms-822608.pdf.

[39] Sentinel Event Alert, Physical and Verbal Violence Against Health Care Workers 5 (2018), https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf.

[40] Darryl Beard and Michelle Conley, Operation Safe Workplace: A Multidisciplinary Approach to Workplace Violence 3 (2017), https://www.jointcommission.org/assets/1/6/Aria_Workplace_Safety.pdf.

[41] Judith E. Arnetz, et al., *Preventing Patient-to-Worker Violence in Hospitals: Outcome of a Randomized Controlled Intervention*, 59 Journal of Occupational and Environmental Medicine 18 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5214512/pdf/nihms-822608.pdf.

> Measures such as "buddy systems," GPS tracking systems, escorts and pre-visit assessments to identify and address potential threats would be required to be instituted. We cannot expect clients to make changes to their home. That is why it is essential that workplaces have in place effective home visit safety measures such as those listed above.[42]

Studies have shown that ensuring the safety of health care and social service workers also benefits patients and clients. Dr. Lipscomb testified at the 2019 WP Subcommittee Hearing that:

> This bill and an OSHA standard would also protect and promote patient safety by reducing the risk of violence from patients and visitors who not only assault workers, but also other patients. Health care worker health and safety and patient safety are inextricably linked. When patient violence is left unchecked, patients also suffer the consequences of such assaults both in terms of increased risk of injury and when care is compromised because health care workers become injured and can no longer provide high quality care.[43]

Patient safety was also enhanced by interventions made to protect workers from workplace violence that resulted in a 28 percent reduction in the use of patient restraints.[44]

And, as Dr. McClain noted in his testimony at the 2019 WP Subcommittee Hearing:

> Further justification for H.R.1309 is the fact that it is essential that settings that provide social services be healing environments. When a client harms a social worker or other professional in these environments, it is traumatizing for the client, not just the person they harmed. It disrupts the therapeutic process and can set back progress by months if not years. Clients witnessing violence are also traumatized, which impedes their progress. Through common sense safety measures, workplaces can reduce or eliminate this primary and secondary trauma, resulting in better outcomes not just for clients but also for the larger community.[45]

Finally, H.R. 1195 does not require OSHA to issue a "one-size-fits-all" standard that prescribes every step that every employer must take. In fact, it is just the opposite. The interim and final standards will be "program standards," which set forth the basic elements of a workplace violence prevention program. The em-

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[42] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. and Labor*, 116th Cong. (2019) (forthcoming McClain response to a question for the record from Rep. Alma Adams).

[43] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. and Labor*, 116th Cong. (2019) (forthcoming Lipscomb response to a question for the record from Rep. Alma Adams).

[44] Yana Dilman, *EB72: Code Green for Workplace Violence*, American Nurse Today (Feb. 2017 Vol. 12 No. 2), https://www.americannursetoday.com/code-green-prevents-workplace-violence/.

[45] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. and Labor*, 116th Cong. (2019) (forthcoming McClain response to a question for the record from Rep. Alma Adams).

ployer will be required to tailor their violence prevention plan according to the size and type of the operation, the specific risks presented, and the types of interventions that are needed to protect workers.

OSHA Has Developed Authoritative Voluntary Guidelines as Part of a Program of Compliance Assistance

For over 20 years, OSHA has conducted compliance assistance activities to assist employers in reducing workplace violence—including the dissemination of best practices. In 1996, OSHA first issued its *Guidelines* which were updated in 2004 and again in 2015. However, OSHA notes that these voluntary guidelines are "advisory in nature and informational in content." Nonetheless, these are frequently cited by industry and safety professionals because the OSHA *Guidelines* are:

> based on industry best practices and feedback from stakeholders and provide recommendations for developing policies and procedures to eliminate or reduce workplace violence in a range of healthcare and social service settings . . . and incorporate the latest and most effective ways to reduce the risk of violence in the workplace.[46]

These *Guidelines* are the foundation for the violence prevention standard required in H.R. 1195.

OSHA's Efforts to Prevent Workplace Violence Have Been Limited by Reliance on the General Duty Clause, Instead of a Specific Standard

When OSHA does not have a standard that specifically addresses a recognized hazard, it must use the General Duty Clause (GDC) of the OSH Act to enforce safe working conditions. The General Duty Clause states 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.[47]

In general, the GDC is poorly suited to the enforcement of protections regarding workplace violence because its use is legally burdensome and faces repeated legal attack by employers who want to categorize workplace violence as a random, unpreventable act rather than a recognized hazard that can be prevented or mitigated. To cite an employer under the general duty clause, OSHA must have evidence that (1) a condition or activity in the workplace presents a hazard to an employee, (2) the condition or activity is recognized as a hazard by the employer or within the industry, (3) the hazard is causing or is likely to cause death or serious physical harm, and (4) a feasible means exists to eliminate or materially reduce the hazard. General Duty Clause citations are frequently challenged in court and are only successfully upheld when OSHA can show in each separate instance that all four prongs can be satisfied. By

[46] Occupational Safety and Health Administration, Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers 1 (2016), https://www.osha.gov/Publications/osha3148.pdf.
[47] 29 U.S.C. § 654(a)(1).

comparison, an OSHA standard delineates mandatory compliance elements. Because of the legal burdens associated with use of the GDC, only a small number of OSHA inspections regarding workplace violence result in citations.[48]

OSHA implemented a 3-year National Emphasis Program (NEP) in 2012 that targeted nursing and residential care facilities and included workplace violence. Inspections of health care employers related to workplace violence increased from 11 inspections per year in 2010 to 86 inspections in 2014.[49] OSHA also issued a workplace violence compliance directive in 2011, which was updated in January 2017,[50] to assist OSHA inspectors in inspecting worksites and building a case under the GDC. From 1991 through October 2014, OSHA issued 18 general duty clause citations to health care employers for failing to address workplace violence. These citations were issued in approximately five percent of the 344 workplace violence inspections of health care employers that were conducted from 1991 to April 2015. In practice, the GDC is used only after a worker has been injured or killed; in all 18 of the cases where OSHA issued citations, health care workers had been injured or killed by patients, clients, or residents.

As noted above, the use of the GDC is under constant legal threat. In the *Integra Health Management* case, which came before the Occupational Safety and Health Review Commission (OSHRC),[51] a community health worker was stabbed to death by a client outside of his residence in 2012. OSHA cited Integra using the General Duty Clause and fined the company $10,500. Integra appealed the citation on the grounds that the "hazard of being assaulted by [a client] with a history of violent behavior" is not a recognized hazard and that abatement of that hazard was not feasible.[52] The U.S. Chamber of Commerce argued that OSHA should not be able to use the GDC in combination with the OSHA *Guidelines* "as a substitute for [its] obligation to enforce the Act principally by promulgating specific standards under the Act's rulemaking provisions."[53] Although OSHRC sustained the citations against Integra, continued attacks on use of the GDC can be expected until OSHA adopts a specific violence prevention standard.

OSHA's Efforts to Promulgate a Workplace Violence Prevention Standard Have Been Halting and Inconsistent

Following the issuance of the 2016 GAO study and the receipt of two petitions for a workplace violence standard, the Obama Admin-

[48] United States Government Accountability Office, Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence (2016), https://www.gao.gov/assets/680/675858.pdf.

[49] United States Government Accountability Office, Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence (2016), https://www.gao.gov/assets/680/675858.pdf.

[50] Occupational Safety and Health Administration, U.S. Department of Labor Directive CPL 02–01–058, Enforcement Procedures and Scheduling for Occupational Exposure to Workplace Violence (2017), https://www.osha.gov/OshDoc/Directive_pdf/CPL_02-01-058.pdf.

[51] Integra Health Management, Inc., 2015 OSAHRC LEXIS 46 (No.13–1124, 2015), https://www.oshrc.gov/assets/1/18/Integra_Health_Management,_Inc._Docket_13-1124_Combined_post.pdf?8328.

[52] Brief of Respondent at 8, Integra Health Management, Inc., 2015 OSAHRC LEXIS 46 (No.13–1124, 2015), https://www.oshrc.gov/assets/1/6/RespondentsPost-HearingBrief.pdf.

[53] Brief for Integra Health Management, Inc., as Amicus Curiae Chamber of Commerce of the United States of America supporting Respondent, 2015 OSAHRC LEXIS 46 (No.13–1124, 2015), https://www.oshrc.gov/assets/1/6/Brief_of_Amicus_Brief_of_Chamber_of_Commerce_of_USA_in_Support_of_Respondent_Integra_Health_Management_Redacted.pdf.

istration added workplace violence to the regulatory agenda and issued a Request for Information to solicit information on the content of a potential standard to prevent workplace violence in health care and social assistance settings.[54] OSHA held a stakeholder meeting on January 10, 2017, at which the Assistant Secretary granted the petitions for rulemaking and announced that the agency would pursue a workplace violence prevention standard.

As former OSHA Assistant Secretary Dr. David Michaels testified at the 2021 WP Subcommittee hearing:

> After reviewing the very extensive and compelling evidence for the need for a regulation, I granted the petitions and announced OSHA would immediately commence the rule-making process.[55]

The Trump Administration's first Regulatory Agenda, issued in the Spring of 2017, relegated work on the workplace violence prevention standard to the "Long-Term Agenda" for a year, but returned it to OSHA's active Regulatory Agenda in May 2018. Over the past two-and-one-half years, OSHA's sole visible effort was a statement in the Regulatory Agenda of its the intent to hold a Small Business Regulatory Enforcement Fairness Act (SBREFA) panel, the earliest stage of the rulemaking process. The panel was originally set to meet in January 2019; OSHA postponed the meeting to March 2019, then to October 2019, then to January 2020, and finally to December 2020. The panel was never initiated.

OSHA was also constrained in prioritizing a workplace violence prevention standard since 2017 due to a presidential mandate to focus on deregulatory efforts. The Trump Administration's Executive Order "Reducing Regulation and Controlling Regulatory Costs" required that for every new regulation an agency adopts, two regulations of the same cost must be eliminated.[56] That mandate has been repealed by the Biden Administration.

Voluntary Guidelines, Compliance Assistance and Enforcement Through the OSH Act's General Duty Clause Are Not Sufficient to Protect Workers

Although OSHA has been conducting compliance assistance activities for 25 years, as noted above, and revised its *Guidelines* in 2015, these activities have not been sufficient to adequately protect workers. Not only are violence-related injury rates increasing, but as Dr. Jane Lipscomb testified at the 2019 WP Subcommittee Hearing:

> [V]oluntary guidelines such as those that were first published by OSHA in 1996 and updated in 2015, do not protect the vast majority of employees, because they fail to incentivize employers to act voluntarily to address this hazard. I can attest to that fact because the vast majority of health care workers who I have spoken with report that they do not have a workplace violence prevention plan or

[54] Request for Information, Prevention of Workplace Violation in Healthcare and Social Assistance, 81 Fed. Reg. 88147 (Dec. 7, 2016).

[55] *Clearing the Air: Science Based Strategies to Protect Workers from COVID–19 Infections, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. and Labor,* 117th Cong. (2021) (written testimony of Dr. David Michaels at 13).

[56] Exec. Order No. 13,7871, 83 Fed. Reg. 9339 (Jan. 30, 2017).

> that they have a paper plan that does little to nothing to protect them from the ongoing risk of violence.[57]

Without a legally enforceable OSHA standard, important elements such as incident investigations may not happen. Patricia Moon-Updike described this situation in a post-2019 WP Subcommittee Hearing submission:

> I am not aware of any investigation of my assault. I was only asked for my account of events for Workers Compensation management purposes. I have no knowledge of any investigations of incidents of workplace violence with or without workers' participation or review of the findings. Wisconsin's Act 10, which placed limits on public employees' collective bargaining rights also precluded the union from participating in an investigation.[58]

State Legislative and Regulatory Activity

Ten states—California, Connecticut, Illinois, Maine, Maryland, Nevada, New Jersey, New York, Oregon, and Washington—have some form of laws or regulations covering workplace violence in health care. Nevada recently passed a comprehensive workplace violence law covering health care workers that will come into full effect in 2021.[59] None of the states cover social service workers with the exceptions of Illinois (covers clinical social workers who work inside a health care facility) and New York (covers public employees, including those in health care and social services, but not private sector employees).[60] Some laws lack enforcement mechanisms. Only four of the nine (California, Washington, Nevada, and New York) have enforcement mechanisms that operate through their state OSHA programs where workers can file complaints and receive an inspection. The Illinois Health Care Violence Prevention Act, which is administered by the Illinois Department of Public Health, requires health care providers (as well as the Departments of Corrections and Juvenile Justice) to develop a workplace violence prevention program modeled on OSHA's *Guidelines,* but the law does not address inspections or consequences for non-compliance.[61]

H.R. 1195 Provides for Robust Public Input into the Rulemaking Process

Input by workers, employers, and experts on the subject of workplace violence is of vital importance in order to issue an effective and feasible OSHA standard. H.R. 1195 requires all of the federal rulemaking requirements, including full notice and comment, for the final workplace violence standard that must be issued within 42 months of the date of enactment.

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[57] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. and Labor,* 116th Cong. (2019) (written Testimony of Jane Lipscomb at 1) [Hereinafter Lipscomb Testimony].

[58] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. and Labor,* 116th Cong. (2019) (forthcoming Moon-Updike response to a question for the record by Rep. Alma Adams).

[59] Assembly Bill 348, 80th Leg., Reg. Sess. (Nev. 2019), https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6646/Text.

[60] N.Y. Comp. Codes R. & Regs. tit. 12 § 800.6 (2006).

[61] H.B. 4100 of the 100th General Assembly [Public Act 100–1051] (Ill. 2018).

Given the rising rates of workplace violence and the need for urgent action to stem injuries to workers, H.R. 1195 requires OSHA to issue an interim final standard within a year, and the bill as introduced waived OSHA's procedural requirements for the interim final standard only. H.R. 1309 was criticized during the 2019 WP Subcommittee Hearing for not allowing sufficient public input prior to issuance of the interim final standard. To address that concern, during the markup of H.R. 1309, the Committee adopted by voice vote an amendment that would add a 30-day comment period prior to issuance of the interim final standard. That 30-day comment period remains in H.R. 1195.

Since there has already been considerable public comment on a potential workplace violence standard through a 2016 Request for Information, advancing to an interim final standard would reflect a solid evidentiary basis supported by industry and other stakeholder input, as well years of experience applying the OSHA *Guidelines*. Dr. Lipscomb noted in her testimony at the 2019 WP Subcommittee Hearing:

> OSHA has already had a request for information around their plan to develop a workplace violence prevention standard. So there certainly was the opportunity in there. I was part of both that hearing and public meeting so there has been input that has already been provided. And there has been input from stakeholders all around the country around these other 9 actual laws and, as I said, experts in health care safety and patient safety have all written documents that recommend pretty much the same measures that are described in this bill.
>
> So, I completely disagree that there hasn't been an opportunity for stakeholder input. In fact, I think there is a consensus in the industry on what is needed.[62]

Absent Congressionally Mandated Deadlines, OSHA Standards Often Take Decades to be Issued

Due to the high number and rate of serious injuries caused by workplace violence and the ready availability of effective and feasible means to prevent or mitigate these assaults, H.R. 1195 sets deadlines for OSHA to protect workers.

In 2012, GAO issued a report regarding the protracted length of time it takes OSHA to issue a standard. It found that:

> Between 1981 and 2010, the time it took the Department of Labor's Occupational Safety and Health Administration (OSHA) to develop and issue safety and health standards ranged widely, from 15 months to 19 years, and averaged more than 7 years.[63]

In order to issue a standard, OSHA must complete multiple steps that, depending on resources and competing priorities, can be quite lengthy. These include:

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[62] *Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence*, YouTube (Mar. 1, 2019), https://www.youtube.com/watch?v=3B9eMBSBKm0 (question and answer between Chairman Scott and Lipscomb at 01:07:22).

[63] United States Government Accountability Office, Workplace Safety and Health: Multiple Challenges Lengthen OSHA's Standard Setting (2012), https://www.gao.gov/assets/590/589825.pdf.

- Request for Information (RFI) and/or an Advance Notice of Proposed Rulemaking (ANPRM): While not mandatory, OSHA often issues an RFI and/or an ANPRM in order to gather information that may be needed for a proposal, or to decide whether a standard is needed. Comment periods usually last several months, followed by OSHA's analysis of the results. OSHA issued an RFI and held a stakeholder meeting in January 2017 on the workplace violence standard.
- Small Business Regulatory Enforcement Fairness Act (SBREFA) Panel: The earliest major step in the regulatory process is a review of the impact of a regulation on small businesses required by SBREFA. "Small Entity Representatives" are chosen to participate in panels describing the possible impact of a new OSHA standard. The findings are then compiled into a report with recommendations that are considered as the agency develops the regulatory proposal. It requires six months from initiation of the SBREFA process to completion of the final report, although several months to a year are generally needed to compile the data needed to initiate the process.
- Proposed Standard: OSHA must issue a proposed standard that will undergo up to three months of review by the Office of Management and Budget's Office of Intergovernmental and Regulatory Affairs (OIRA). The proposal contains a draft regulatory text, suggested alternatives, and a Preliminary Regulatory Flexibility Analysis (RFA) that explains the costs and benefits of that rule. The RFA contains an extensive justification of the economic and technical feasibility of the standard and the presentation of regulatory alternatives for consideration. It often takes OSHA several years to move from SBREFA to a proposed rule.
- Hearings and Comment Period: Following the issuance of the proposal, OSHA usually provides a 60–90 day written comment period, followed by public hearings, which can last from a few days to several weeks. Another written comment period, generally 60–90 days, follows the hearings.
- Final Standard: Following the completion of the hearing and public comment periods, OSHA is required to analyze and respond to each of the comments on the proposal received during the public comment periods and hearings, and based on that input, make appropriate changes in the regulation and develop a Final Regulatory Flexibility Analysis which is again submitted to OIRA for a three-month review before the final standard is issued. It often takes several years to move from the proposal to the final standard.

While all the above cited requirements would be in effect for the final standard, in order for health care and social service workers to receive timely protection against workplace violence, the interim final standard would require a 30 day comment period but would suspend these other requirements.

Recent trends show that GAO's assessment from 2012 underestimates the average time it now takes for OSHA to issue new safety and health standards. Set forth below are recent OSHA standards and the time required to finalize each standard.

- Beryllium (18 years): OSHA issued its final Beryllium standard in January 2017[64] after beginning the most recent rulemaking process in 1999. This was OSHA's second attempt to update its 1971 beryllium standard. OSHA first issued a proposal to update its beryllium standard in 1975, but the standard was never completed.
- Crystalline Silica (19 Years): OSHA issued its final Silica standard in March 2016[65] after the issue was placed on the Regulatory Agenda in 1997. This was OSHA's second attempt to update its silica standard. The agency issued its first Advance Notice of Proposed Rulemaking in 1975 but no proposal was ever issued.
- Confined Spaces in Construction (22 years): In May 2015, OSHA issued a Confined Spaces in Construction standard[66] after first committing to issue this standard in 1993 and issuing a draft proposed standard in 1994. This was OSHA's second attempt to regulate confined spaces in the construction industry. OSHA published an Advanced Notice of Proposed Rulemaking in 1980, but that action was never completed.
- Walking Working Surfaces (14 years): In 2017, OSHA issued its revised Walking Working Surfaces standard[67] after initiating the regulatory process in 2003. This was OSHA's third attempt to update this rule. OSHA's first proposed rule updating this standard was issued in 1973 and a second proposed rule was issued in 1990. Neither of these efforts were completed.

Former OSHA Assistant Secretary Dr. David Michaels, testifying the 2021 WP Subcommittee Hearing, strongly endorsed H.R. 1195, stating that "Normally, it takes OSHA a decade or more to issue a health standard."[68]

Completion of a Final Standard in 42 Months is Achievable

OSHA should be able to finalize a workplace violence standard within the 42-month period that is set forth in H.R. 1195. First, OSHA would not be starting from scratch. The main elements of this standard are contained in OSHA's *Guidelines,* which were revised in 2015. These *Guidelines* form the basis for many existing workplace violence programs in health care institutions today. Second, California has adopted a comprehensive workplace violence standard that contains most of the same elements contained in H.R. 1195 and should provide important information about the feasibility, costs, and benefits of the measures required in H.R. 1195. Third, OSHA would be building a final rule on the foundation set forth in the interim final standard, which must be issued within one year of enactment.

[64] 29 C.F.R. §1910.1024 (2017), 29 C.F.R. §1926.1124 (2018), and 29 C.F.R. §1915.1024 (2017).
[65] 29 C.F.R. §1910.1053 (2016) and 29 C.F.R. §1926.1153 (2016).
[66] 29 C.F.R. §1926.1200–1213 (2015).
[67] 29 C.F.R. §1910 Parts D and I (2016).
[68] *Clearing the Air: Science Based Strategies to Protect Workers from COVID–19 Infections, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. and Labor,* 117th Cong. (2021) (written testimony of Dr. David Michaels at 13).

History of Congressionally Directed OSHA Rulemaking

Congress has a long history of requiring OSHA to issue regulations to protect workers when the agency fails to act in a timely manner on its own. H.R. 1195 continues Congress' precedent of requiring OSHA to act promptly when faced with evidence that our nation's workers face grave dangers and delay will result in needless injury, illness, and death. For example:

- In 1986, as part of the Superfund Amendments and Reauthorization Act of 1996 (SARA), Congress required that OSHA issue an "interim" standard for Hazardous Waste Operations and Emergency Response within 60 days and a final standard within one year of SARA's enactment. The standard was issued in 1989.[69]
- In 1990, as part of the Clean Air Act Amendments, Congress required OSHA to issue the Process Safety Management standard within one year. Congress also included detailed directions on the content of the standard. The standard was issued in 1992.[70]
- In 1991, Congress ordered OSHA to issue the final Bloodborne Pathogens Standard by the end of 1991, and stated that if that deadline was not met, the previously published proposed standard would take effect. The standard was issued in 1991.[71]
- In 1992, Congress required OSHA to issue the Lead in Construction standard and required the new standard to be "as protective as" the U.S. Department of Housing and Urban Development's worker protection guidelines for identification and abatement of lead-based paint in certain housing. OSHA was required to issue an Interim Final Regulation for lead within 180 days. The standard was issued in 1993.[72]
- Finally, in 2000, Congress required OSHA to issue an update to the Bloodborne Pathogens standard, requiring safer syringes and sharps, "without regard to the procedural requirements applicable to regulations promulgated under section 6(b) of the OSH Act (29 U.S.C. 655(b)) or the procedural requirements of chapter 5 of title 5, United States Code."[73] OSHA was required to issue that standard within six months of enactment. The standard was issued in 2001.

H.R. 1195 Provides Protection to Workers Employed by State and Local Governments in Health Care and Social Service Settings Where Federal OSHA Provides No Coverage

As noted above, public sector health care and social service workers are almost nine times more likely to be injured by an assault than private sector health care workers, and in 24 states these public sector workers lack OSHA protections. There is precedent for Congress to ensure the enforcement of OSHA standards affecting public sector health care workers in those states that do not

[69] Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99–499, § 126 a–f, 100 Stat. 1690–92.
[70] 1990 Clean Air Act Amendments, Pub. L. No. 101–549, § 304, 104 Stat. 2576–77.
[71] Departments of Labor, Health and Human Services and Education and Related Agencies Appropriations Act, Pub. L. No. 102–170, § 100, 105 Stat. 1113 (1991).
[72] Housing and Community Development Act of 1992, Pub. L. No. 102–550, § 402, 106 Stat. 3914.
[73] Needlestick Safety and Prevention Act, Pub. L. No. 106–430, 114 Stat. 1901 (2000).

provide OSHA coverage for public employees by amending the requirements for providers receiving Medicare funds.

In 2003, Congress passed the Medicare Prescription Drug Improvement and Modernization Act, which included a requirement for public employers in the health care sector that receive Medicare funds, but are not covered by Federal or state OSHA, to comply with OSHA's bloodborne pathogens standard.[74]

Section 947(a)(2) of that 2003 law states that providers that violate OSHA's bloodborne pathogens standard are "not subject to termination of an agreement under this section," but are subject to a civil monetary penalty that is similar to the amount of civil penalties that may be imposed under the OSH Act for a violation of the Bloodborne Pathogens standard. The current maximum penalty for a serious violation of an OSHA standard is $13,260, although the average OSHA citation for a serious violation is approximately $3,000.

H.R. 1195 mirrors that 2003 provision by requiring hospitals and skilled nursing facilities operated by state and local governments that receive Medicare funds, but are not covered by Federal OSHA or a state OSHA plan, to comply with OSHA's workplace violence prevention standard that will be issued by OSHA as mandated by H.R. 1195.

[74] The Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. No. 108–173, § 947, 117 Stat. 2066, 2425 (2003).

APPENDIX A

Workplace Violence Rates Among State Government Employees

Databases, Tables & Calculators by Subject

Nonfatal cases involving days away from work: selected characteristics (2011 forward)

Series Id: CSUE1X29205330700
Area: All U.S.
Ownership: State government
Data Type: Injury and illness rate per 10,000 full-time workers
Case Type: Industry division or selected characteristic by detailed occupation
Category: Event - Violence and other injuries by persons or animal
Occupation: Psychiatric technicians

Year	Annual
2011	242.2
2012	373.9
2013	234.8
2014	383.0
2015	448.1
2016	507.8
2017	591.4
2018	505.5
2019	429.6

Data extracted on: March 17, 2021 (5:20:59 PM)

Nonfatal cases involving days away from work: selected characteristics (2011 forward)

Series Id: CSUE1X21102330700
Area: All U.S.
Ownership: State government
Data Type: Injury and illness rate per 10,000 full-time workers
Case Type: Industry division or selected characteristic by detailed occupation
Category: Event - Violence and other injuries by persons or animal
Occupation: Mental health and substance abuse social workers

Year	Annual
2011	52.2
2012	54.0
2013	108.1
2014	131.2
2015	113.0
2016	191.0
2017	278.7
2018	61.1

Nonfatal cases involving days away from work: selected characteristics (2011 forward)

Series Id: CSUE1X31101330700
Area: All U.S.
Ownership: State government
Data Type: Injury and illness rate per 10,000 full-time workers
Case Type: Industry division or selected characteristic by detailed occupation
Category: Event - Violence and other injuries by persons or animal
Occupation: Psychiatric aides

Year	Annual
2011	825.6
2012	685.8
2013	882.0
2014	636.6
2015	612.8
2016	743.8
2017	693.4
2018	1009.8
2019	1460.1

Data extracted on: March 17, 2021 (5:30:55 PM)

Nonfatal cases involving days away from work: selected characteristics (2011 forward)

Series Id: CSUE1X31101430700
Area: All U.S.
Ownership: State government
Data Type: Injury and illness rate per 10,000 full-time workers
Case Type: Industry division or selected characteristic by detailed occupation
Category: Event - Violence and other injuries by persons or animal
Occupation: Nursing assistants

Year	Annual
2012	276.7
2013	205.5
2014	141.1
2015	238.1
2016	156.2
2017	155.2
2018	132.1

Data extracted on: March 17, 2021 (5:29:22 PM)

Nonfatal cases involving days away from work: selected characteristics (2011 forward)

Series Id: CSUF1X3110103O700
Area: All U.S.
Ownership: State government
Data Type: Injury and illness rate per 10,000 full-time workers
Case Type: Industry division or selected characteristic by detailed occupation
Category: Event - Violence and other injuries by persons or animal
Occupation: Nursing, psychiatric, and home health aides

Year	Annual
2011	406.6
2012	435.9
2014	340.1
2015	357.6
2016	370.0
2017	339.9
2018	412.8

Data extracted on: March 17, 2021 (5:27:50 PM)

Nonfatal cases involving days away from work: selected characteristics (2011 forward)

Series Id: CSUE1X3100003O700
Area: All U.S.
Ownership: State government
Data Type: Injury and illness rate per 10,000 full-time workers
Case Type: Industry division or selected characteristic by detailed occupation
Category: Event - Violence and other injuries by persons or animal
Occupation: Healthcare support occupations

Year	Annual
2011	357.7
2012	330.1
2013	353.4
2014	255.1
2015	263.1
2016	285.8
2017	256.0
2018	316.1
2019	506.6

Data extracted on: March 23, 2021 (6:12:08 PM)

Nonfatal cases involving days away from work: selected characteristics (2011 forward)

Series Id: CSUE11SP2HSA63100
Area: All U.S.
Ownership: Private industry
Data Type: Injury and illness Cases
Case Type: Selected characteristic by detailed industry
Category: Event - Intentional injury by other person
Industry: Health care and social assistance

Year	Annual
2011	8180
2012	9170
2013	10450
2014	11100
2015	11200
2016	11830
2017	13080
2018	15230
2019	14550

Data extracted on: March 24, 2021 (6:16:29 PM)

Nonfatal cases involving days away from work: selected characteristics (2011 forward)

Series Id: CSUE1100000063100
Area: All U.S.
Ownership: Private industry
Data Type: Injury and illness Cases
Case Type: Selected characteristic by detailed industry
Category: Event - Intentional injury by other person
Industry: All Industry

Year	Annual
2011	11690
2012	12780
2013	13800
2014	15980
2015	16160
2016	16890
2017	18400
2018	20790
2019	20870

SECTION-BY-SECTION ANALYSIS

Title I. Workplace Violence Prevention Standard

Section 101. Workplace violence prevention standard

This section requires OSHA to issue a workplace violence prevention standard requiring employers within the health care and social service sectors to develop and implement a plan to protect their employees from workplace violence. OSHA shall carry this out in two stages: an interim final standard shall be issued within one year of enactment, and then a final standard shall be issued within 42 months of the date of enactment. The interim final standard shall be based upon the OSHA *Guidelines* and the requirements set forth in this bill. A 30-day comment period will be provided before issuance of the interim final standard.

Section 102. Scope and application

The interim and final standards will cover hospitals, residential treatment facilities, non-residential treatment settings, medical treatment or social service settings in correctional or detention facilities, psychiatric treatment facilities, substance use disorder treatment centers, community care settings such as group homes and mental health clinics, freestanding emergency centers, federal health care facilities such as those operated by the Veterans Administration and the Indian Health Service, field work settings such as home care and home-based hospice, and emergency services and transport services. The standards would not cover employer-provided health care facilities.

The interim and final standards cover direct-hire employees, contracted and subcontracted employees, and temporary or leased employees employed by a covered employer at a covered facility or performing covered services on behalf of a covered employer. However, the interim and final standards exclude an individual who privately employs persons in the individual's residence to perform covered services for the individual or a family member of the individual.

Section 103. Requirements for the workplace violence prevention standard

The legislation directs OSHA to establish a standard that:

(1) Requires each covered employer to develop and implement a Workplace Violence Prevention Plan (Plan) tailored to the relevant hazards in the specific facility.

- In preparing a Plan, covered employers, in conjunction with employees (and their representatives where applicable), shall identify workplace violence risks to employees in their particular workplace, including environmental risk factors, risk factors specific to the patient population, and past violent incidents.
- Covered employers are responsible for implementing techniques or interventions that prevent hazards.

(2) Requires that the Plan include, as appropriate to the particular work setting, both work practice controls such as security, staffing, and training on de-escalation techniques, and engineering controls such as personal alarm devices, adequate exit routes, sur-

veillance monitoring systems, barrier protection, entry procedures, and weapons detectors. The Plan must outline procedures for reporting, responding to, and investigating incidents, and providing medical care and first aid to affected employees. The Plan must include procedures for training of the workforce, coordination with other employers who have employees who work at the site, and an annual evaluation of the Plan.

(3) Requires that covered employers investigate each incident of workplace violence as soon as practicable, document the findings, and take corrective measures.

(4) Requires that each covered employer provide annual in-person training and education to employees, although annual refresher training may be done through live video conference if in-person training is impracticable. When employees are reassigned, they must receive additional training.

(5) Requires that employers must record workplace violence incidents in a Violent Incident Log (Log). An annual summary of the Log shall be posted in the workplace in the same manner as the posting of the OSHA Annual Summary of Injuries and Illnesses, and similarly, the summary of the Log shall be transmitted to OSHA on an annual basis. Employers shall maintain records related to the Plan, and employees are provided the right to examine and make copies of the Plan, the Log, and related Plan documents, with appropriate protections for patient and worker privacy. Patient names and personal identifying information will be excluded from the Log.

(6) Requires each covered employer to report to OSHA on an annual basis the frequency, quantity, and severity of workplace violence, and any incident response and post incident investigation (including abatement measures) for the incidents set forth in the summary of the Log. OSHA is required to submit an annual report to Congress summarizing employer reports.

(7) Requires each covered employer to conduct an annual evaluation, with the participation of covered employees and their representatives, on the implementation and the effectiveness of the Plan, including a review of the Log and the required training. The employer's plan shall be updated based on the findings of the annual evaluation.

(8) Prohibits retaliation by a covered employer against a covered employee for reporting a workplace violence incident, threat, or concern to an employer, law enforcement, local emergency services, or a government agency. A violation of this prohibition shall be enforceable as a violation of an OSHA standard. Covered employers must adopt a policy prohibiting retaliation.

Section 104. Rules of construction

This section states that nothing in this legislation curtails or limits the authority of the Secretary of Labor under any other provision of federal or state law or any collective bargaining agreement. The rights, privileges, and remedies of employees provided under this legislation are in addition to those provided under any other federal or state law.

Section 105. Key definitions

This section includes key definitions. The term "workplace violence" means: (i) any act of violence or threat of violence, without regard to intent, and includes the threat or use of physical force against an employee that results in or has a high likelihood of resulting in physical injury, psychological trauma, or stress, without regard to whether an employee sustains actual physical injury, psychological trauma, or stress; and (ii) an incident involving the threat or use of a firearm or a dangerous weapon, including the use of common objects as weapons, without regard to whether an employee sustains an actual injury, psychological trauma, or stress.

The terms "Type 1 violence" (criminal intent), "Type 2 violence" (customer or client initiated), "Type 3 violence" (worker on worker) and "Type 4 violence" (personal relationships) are incorporated based on the nomenclature developed by the National Institute for Occupational Safety and Health.

The term "engineering controls" means: an aspect of the built space or a device that removes a hazard from the workplace or creates a barrier between a covered employee and the hazard. This includes electronic access controls to employee occupied areas, weapons detectors (installed or handheld), enclosed workstations with shatter-resistant glass, deep service counters, separate rooms or areas for high risk patients, locks on doors, removing access to or securing items that could be used as weapons, furniture affixed to floors, opaque glass in patient rooms (which protects privacy, but allows the health care provider to see where the patent is before entering the room), closed circuit monitoring and video recording, sight aids, and personal alarm devices.

The term "work practice controls" means: procedures and rules that are used to effectively reduce workplace violence, which include (i) assigning and placing sufficient numbers of staff to reduce patient-specific Type 2 workplace violence hazards; (ii) provision of dedicated and available safety personnel, such as security guards; (iii) employee training on workplace violence prevention methods and techniques to de-escalate and minimize violent behavior; and (iv) employee training on procedures for response in the event of a workplace violence incident and for post-incident response.

Title II. Amendments to the Social Security Act

Section 201. Application of the Workplace Violence Prevention Standard to certain facilities receiving Medicare funds

This section requires that hospitals and skilled nursing facilities operated by state or local government agencies, which are not otherwise subject to the OSH Act or a state occupational safety and health plan, shall comply with the OSHA standard required in this Act as a condition of receiving Medicare funds. A covered facility that fails to comply with the OSHA standard is subject to a civil monetary penalty in an amount similar to the amount OSHA may impose under the OSH Act for a violation of a standard, but such facility is not subject to termination of an agreement with Medicare for failure to comply.

EXPLANATION OF AMENDMENTS

The amendments, including the amendment in the nature of a substitute, are explained in the descriptive portions of this report.

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

H.R. 1195 does not apply to terms and conditions of employment or to access to public services or accommodations within the legislative branch.

UNFUNDED MANDATE STATEMENT

Pursuant to Section 423 of the *Congressional Budget and Impoundment Control Act of 1974,* Pub. L. No. 93–344 (as amended by Section 101(a)(2) of the *Unfunded Mandates Reform Act of 1995,* Pub. L. No. 104–4), the Committee traditionally adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office (CBO) pursuant to section 402 of the *Congressional Budget and Impoundment Control Act of 1974.* The Committee reports that because this cost estimate was not timely submitted to the Committee before the filing of this report, the Committee is not in a position to make a cost estimate for H.R. 1195, as amended.

EARMARK STATEMENT

In accordance with clause 9 of rule XXI of the Rules of the House of Representatives, H.R. 1195 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as described in clauses 9(e), 9(f), and 9(g) of rule XXI.

ROLL CALL VOTES

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the Committee advises that the following roll call votes occurred during the Committee's consideration of H.R. 1195:

Date: 3/24/21

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 1 Bill: H.R. 1195 Amendment Number: 2

Disposition: Defeated by a vote of 20 - 27

Sponsor/Amendment: Walberg/WALBER_017.XML

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)		X		Mrs. FOXX (NC) (Ranking)	X		
Mr. GRIJALVA (AZ)		X		Mr. WILSON (SC)	X		
Mr. COURNTEY (CT)		X		Mr. THOMPSON (PA)	X		
Mr. SABLAN (MP)		X		Mr. WALBERG (MI)	X		
Ms. WILSON (FL)			X	Mr. GROTHMAN (WI)	X		
Ms. BONAMICI (OR)		X		Ms. STEFANIK (NY)	X		
Mr. TAKANO (CA)		X		Mr. ALLEN (GA)	X		
Ms. ADAMS (NC)		X		Mr. BANKS (IN)	X		
Mr. DESAULNIER (CA)		X		Mr. COMER (KY)	X		
Mr. NORCROSS (NJ)			X	Mr. FULCHER (ID)	X		
Ms. JAYAPAL (WA)		X		Mr. KELLER (PA)	X		
Mr. MORELLE (NY)		X		Mr. MURPHY (NC)	X		
Ms. WILD (PA)		X		Ms. MILLER-MEEKS (IA)	X		
Mrs. MCBATH (GA)		X		Mr. OWENS (UT)	X		
Mrs. HAYES (CT)		X		Mr. GOOD (VA)		X	
Mr. LEVIN (MI)		X		Mrs. MCCLAIN (MI)	X		
Ms. OMAR (MN)		X		Mrs. HARSHBARGER (TN)	X		
Ms. STEVENS (MI)		X		Mrs. MILLER (IL)		X	
Ms. LEGER FERNANDEZ (NM)		X		Mrs. SPARTZ (IN)	X		
Mr. JONES (NY)		X		Mr. FITZGERALD (WI)	X		
Ms. MANNING (NC)		X		Mr. CAWTHORN (NC)	X		
Mr. MRVAN (IN)		X		Mrs. STEEL (CA)	X		
Mr. BOWMAN (NY)		X		*Vacancy*			
Mr. POCAN (WI)		X		*Vacancy*			
Mr. CASTRO (TX)		X					
Ms. SHERRILL (NJ)		X					
Mr. YARMUTH (KY)		X					
Mr. ESPAILLAT (NY)			X				
Mr. KWEISI MFUME (MD)			X				

TOTALS: Ayes: 20 Nos: 27 Not Voting: 4

Total: 53 / Quorum: 27/ Report: 27

(29 D - 24 R)

^Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 3/24/2021

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call:2 Bill: H.R. 1195 Amendment Number: Motion

Disposition: Adopted by a vote of 27 - 20

Sponsor/Amendment: Bowman/to report to the House with an amendment and with the recommendation that the amendment be agreed to, and the bill as amended, do pass

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)	X			Mrs. FOXX (NC) (Ranking)		X	
Mr. GRIJALVA (AZ)	X			Mr. WILSON (SC)		X	
Mr. COURNTEY (CT)	X			Mr. THOMPSON (PA)		X	
Mr. SABLAN (MP)	X			Mr. WALBERG (MI)		X	
Ms. WILSON (FL)			X	Mr. GROTHMAN (WI)		X	
Ms. BONAMICI (OR)	X			Ms. STEFANIK (NY)	X		
Mr. TAKANO (CA)	X			Mr. ALLEN (GA)		X	
Ms. ADAMS (NC)	X			Mr. BANKS (IN)		X	
Mr. DESAULNIER (CA)	X			Mr. COMER (KY)		X	
Mr. NORCROSS (NJ)			X	Mr. FULCHER (ID)		X	
Ms. JAYAPAL (WA)	X			Mr. KELLER (PA)		X	
Mr. MORELLE (NY)	X			Mr. MURPHY (NC)	X		
Ms. WILD (PA)	X			Ms. MILLER-MEEKS (IA)		X	
Mrs. MCBATH (GA)	X			Mr. OWENS (UT)		X	
Mrs. HAYES (CT)	X			Mr. GOOD (VA)		X	
Mr. LEVIN (MI)	X			Mrs. MCCLAIN (MI)		X	
Ms. OMAR (MN)	X			Mrs. HARSHBARGER (TN)		X	
Ms. STEVENS (MI)	X			Mrs. MILLER (IL)		X	
Ms. LEGER FERNANDEZ (NM)	X			Mrs. SPARTZ (IN)		X	
Mr. JONES (NY)	X			Mr. FITZGERALD (WI)		X	
Ms. MANNING (NC)	X			Mr. CAWTHORN (NC)		X	
Mr. MRVAN (IN)	X			Mrs. STEEL (CA)		X	
Mr. BOWMAN (NY)	X			*Vacancy*			
Mr. POCAN (WI)	X			*Vacancy*			
Mr. CASTRO (TX)	X						
Ms. SHERRILL (NJ)	X						
Mr. YARMUTH (KY)	X						
Mr. ESPAILLAT (NY)			X				
Mr. KWEISI MFUME (MD)			X				

TOTALS: Ayes: 27 Nos: 20 Not Voting: 4

Total: 53 / Quorum: 27/ Report: 27

(29 D - 24 R)

^Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

STATEMENT OF PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause (3)(c) of rule XIII of the Rules of the House of Representatives, the goals of H.R. 1195 are to protect health care and social service workers from workplace violence.

DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that no provision of H.R. 1195 establishes or reauthorizes a program of the Federal Government known to be duplicative of another federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

HEARINGS

Pursuant to clause 3(c)(6) of rule XIII of the Rules of the House of Representatives, on March 11, 2021, the Committee held a hearing entitled "Clearing the Air: Science Based Strategies to Protect Workers from COVID–19 Infections," which was used to consider H.R. 1195. The Committee heard testimony from Pascaline Muhindura, a nurse at Research Medical Center, Kansas City, MO, who described the hazards nurses in her hospital face from workplace violence and how those hazards have increased during the COVID pandemic. Former Assistant Secretary for OSHA, Dr. David Michaels, testified on the need for legislation that would set strict deadlines to issue this important OSHA standard.

STATEMENT OF OVERSIGHT AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the descriptive portions of this report.

NEW BUDGET AUTHORITY AND CBO COST ESTIMATE

Pursuant to clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the *Congressional Budget and Impoundment Control Act of 1974,* and pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the *Congressional Budget and Impoundment Control Act of 1974,* the Committee has requested but not received a cost estimate for the bill from the Director of the Congressional Budget Office.

COMMITTEE COST ESTIMATE

Clause 3(d)(1) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 1195. However, clause 3(d)(2)(B) of that rule provides that this requirement does not apply when the committee has included in its report a timely submitted cost estimate of the bill prepared by the Director of the Con-

gressional Budget Office under section 402 of the *Congressional Budget and Impoundment Control Act of 1974.* The Committee reports that because this cost estimate was not timely submitted to the Committee before the filing of this report, the Committee is not in a position to make a cost estimate for H.R. 1195, as amended.

CHANGES IN EXISITNG LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, H.R. 1195, as reported, are shown as follows:

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART E—MISCELLANEOUS PROVISIONS

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES; ENROLLMENT PROCESSES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A)(i) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and (ii) not to impose any charge that is prohibited under section 1902(n)(3),

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1862(a), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and serv-

ices was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of title XI as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1886, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a quality improvement organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews),

(ii) in the case of hospitals, critical access hospitals, rural emergency hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a quality improvement organization (which has a contract with the Secretary under part B of title XI for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(A),

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2),

(H)(i) in the case of hospitals which provide services for which payment may be made under this title and in the case of critical access hospitals which provide critical access hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14), and other than services described by section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) (I) that are furnished to an individual who is a patient of the hospital, and (II) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital,

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

(I) that are furnished to an individual who is a resident of the skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1861(s)(2)(D), that are furnished to such an individual without regard to such period), and

(II) for which the individual is entitled to have payment made under this title,

to have items and services (other than services described in section 1888(e)(2)(A)(ii)) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,

(I) in the case of a hospital, critical access hospital, or rural emergency hospital—

(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1867 and to meet the requirements of such section,

(ii) to maintain medical and other records related to individuals transferred to or from the hospital, critical access hospital, or rural emergency hospital for a period of five years from the date of the transfer, and

(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition,

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to

be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code,

(K) not to charge any individual or any other person for items or services for which payment under this title is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B),

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under chapter 17 of title 38, United States Code, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Secretary of Veterans Affairs in implementation of such section,

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this title,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,—and which provides such additional information as the Secretary may specify,

(N) in the case of hospitals, critical access hospitals, and rural emergency hospitals—

(i) to make available to its patients the directory or directories of participating physicians (published under section 1842(h)(4)) for the area served by the hospital, critical access hospital, or rural emergency hospital,

(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services,

(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying

rights of individuals under section 1867 with respect to examination and treatment for emergency medical conditions and women in labor, and

(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital, critical access hospital, or rural emergency hospital participates in the medicaid program under a State plan approved under title XIX,

(O) to accept as payment in full for services that are covered under this title and are furnished to any individual enrolled with a Medicare+Choice organization under part C, with a PACE provider under section 1894 or 1934, or with an eligible organization with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, which does not have a contract (or, in the case of a PACE provider, contract or other agreement) establishing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider, the amounts that would be made as a payment in full under this title (less any payments under sections 1886(d)(11) and 1886(h)(3)(D)) if the individuals were not so enrolled,

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy car (described in section 1861(m)(5)), to offer to furnish such supplies to such an individual as part of their furnishing of home health services,

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives),

(R) to contract only with a health care clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the health care clearinghouse is required to comply with the standard or specification,

(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1861(ee)(2)(H)(ii), or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

(i) the nature of such financial interest,

(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

(iii) the percentage of such individuals who received such services from such provider (or another such provider),

(T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines

appropriate pursuant to subparagraph (E) of section 1886(d)(12) to carry out such section,

(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care both—

(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services,

(V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated),

(W) in the case of a hospital described in section 1886(d)(1)(B)(v), to report quality data to the Secretary in accordance with subsection (k),

(X) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary, [and]

(Y) beginning 12 months after the date of the enactment of this subparagraph, in the case of a hospital or critical access hospital, with respect to each individual who receives observation services as an outpatient at such hospital or critical access hospital for more than 24 hours, to provide to such individual not later than 36 hours after the time such individual begins receiving such services (or, if sooner, upon release)—

(i) such oral explanation of the written notification described in clause (ii), and such documentation of the provision of such explanation, as the Secretary determines to be appropriate;

(ii) a written notification (as specified by the Secretary pursuant to rulemaking and containing such language as the Secretary prescribes consistent with this paragraph) which—

(I) explains the status of the individual as an outpatient receiving observation services and not as an

inpatient of the hospital or critical access hospital and the reasons for such status of such individual;

(II) explains the implications of such status on services furnished by the hospital or critical access hospital (including services furnished on an inpatient basis), such as implications for cost-sharing requirements under this title and for subsequent eligibility for coverage under this title for services furnished by a skilled nursing facility;

(III) includes such additional information as the Secretary determines appropriate;

(IV) either—

(aa) is signed by such individual or a person acting on such individual's behalf to acknowledge receipt of such notification; or

(bb) if such individual or person refuses to provide the signature described in item (aa), is signed by the staff member of the hospital or critical access hospital who presented the written notification and includes the name and title of such staff member, a certification that the notification was presented, and the date and time the notification was presented; and

(V) is written and formatted using plain language and is made available in appropriate languages as determined by the Secretary[.]*; and*

(Z) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act) and skilled nursing facilities that are not otherwise subject to such Act (or such a State occupational safety and health plan), to comply with the Workplace Violence Prevention Standard (as promulgated under section 101 of the Workplace Violence Prevention for Health Care and Social Service Workers Act).

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of title XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such

items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A) and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1834(a), the amount of any deduction imposed under section 1833(b) and 20 percent of the payment basis described in section 1834(a)(1)(B). In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5). In the case of services described in section 1833(a)(8) or section 1833(a)(9) for which payment is made under part B under section 1834(k), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2), except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of subparagraph (C), whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1813(a)(2).

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of section 1866(a)(2)(B)(ii), charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this title if the admitting physician has a direct or indirect financial interest in such provider.

(3)(A) Under the agreement required under paragraph (1)(F)(ii), the quality improvement organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1154(a)(4)(A) and under section 1154(a)(14) with respect to services, furnished by the hospital, critical access hospital, rural emergency hospital, facility, or agency involved, for which payment may be made under this title.

(B) For purposes of payment under this title, the cost of such an agreement to the hospital, critical access hospital, rural emergency hospital, facility, or agency shall be considered a cost incurred by such hospital, critical access hospital, rural emergency hospital, facility, or agency in providing covered services under this title and shall be paid directly by the Secretary to the quality improvement organization on behalf of such hospital, critical access hospital, rural emergency hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for a fiscal year—

(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

(II) in the case of facilities, critical access hospitals, rural emergency hospitals, and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities, critical access hospitals, rural emergency hospitals, or agencies under part B of title XI.

(b)(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions

of this title and regulations thereunder, or with a corrective action required under section 1886(f)(2)(B),

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861,

(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A, or

(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation under the programs under this title becomes effective under section 1128(c).

(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(V) (relating to the Bloodborne Pathogens standard) *and a hospital or skilled nursing facility that fails to comply with the requirement of subsection (a)(1)(Z) (relating to the Workplace Violence Prevention Standard)* is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection [(a)(1)(U)] *(a)(1)(V)* by a hospital that is subject to the provisions of such Act *(or, in the case of a failure to comply with the requirement of subsection (a)(1)(Z), for a violation of the Workplace Violence Prevention standard referred to in such subsection by a hospital or skilled nursing facility, as applicable, that is subject to the provisions of such Act)*.

(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

(c)(1) Where the Secretary has terminated or has refused to renew an agreement under this title with a provider of services, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination or nonrenewal has been removed and that there is reasonable assurance that it will not recur.

(2) Where the Secretary has terminated or has refused to renew an agreement under this title with a provider of services, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of such termination or nonrenewal.

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital, he may, in lieu of terminating his agreement with such hospital, decide that, with respect to any individual admitted to such hospital after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient psychiatric hospital services) after the

20th day of a continuous period of such services. Such decision may be made effective only after such notice to the hospital and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) For purposes of this section, the term "provider of services" shall include—

(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1861), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1861), but only with respect to the furnishing of outpatient physical therapy services (as therein defined), (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services, or (through the operation of section 1861(ll)(2)) with respect to the furnishing of outpatient speech-language pathology;

(2) a community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)); and

(3) opioid treatment programs (as defined in paragraph (2) of section 1861(jjj)), but only with respect to the furnishing of opioid use disorder treatment services (as defined in paragraph (1) of such section).

(f)(1) For purposes of subsection (a)(1)(Q) and sections 1819(c)(2)(E), 1833(s), 1855(i), 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services, Medicare+Choice organization, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the written policies of the provider or organization respecting the implementation of such rights;

(B) to document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a skilled nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of an eligible organization (as defined in section 1876(b)) or an organization provided payments under section 1833(a)(1)(A) or a Medicare+Choice organization, at the time of enrollment of the individual with the organization.

(3) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(4) For construction relating to this subsection, see section 7 of the Assisted Suicide Funding Restriction Act of 1997 (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(g) Except as permitted under subsection (a)(2), any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under subsection (a)(1)(H) or in violation of the requirement for such an arrangement, is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(h)(1)(A) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expe-

dited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.

(C)(i) The Secretary shall develop and implement a process to expedite proceedings under this subsection in which—

(I) the remedy of termination of participation has been imposed;

(II) a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) has been imposed, but only if such remedy has been imposed on an immediate basis; or

(III) a determination has been made as to a finding of substandard quality of care that results in the loss of approval of a skilled nursing facility's nurse aide training program.

(ii) Under such process under clause (i), priority shall be provided in cases of termination described in clause (i)(I).

(iii) Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues.

(i)(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this title and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may terminate such agreement, or provide that no payment will be made under this title with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this title—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this title with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no payment may be made under this title with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this title.

(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

(1) ENROLLMENT PROCESS.—

(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title. Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (5), the imposition of temporary enrollment moratoria in accordance with paragraph (7), and the establishment of compliance programs in accordance with paragraph (9).

(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

(2) PROVIDER SCREENING.—

(A) PROCEDURES.—Not later than 180 days after the date of enactment of this paragraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

(B) LEVEL OF SCREENING.—The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

(i) shall include a licensure check, which may include such checks across States; and

(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—

(I) a criminal background check;

(II) fingerprinting;

(III) unscheduled and unannounced site visits, including preenrollment site visits;

(IV) database checks (including such checks across States); and

(V) such other screening as the Secretary determines appropriate.

(C) APPLICATION FEES.—

(i) INSTITUTIONAL PROVIDERS.—Except as provided in clause (ii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nurs-

ing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

(I) for 2010, $500; and

(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

(ii) HARDSHIP EXCEPTION; WAIVER FOR CERTAIN MEDICAID PROVIDERS.—The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of the fee would impede beneficiary access to care.

(iii) USE OF FUNDS.—Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1128J.

(D) APPLICATION AND ENFORCEMENT.—

(i) NEW PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this title, title XIX, or title XXI as of the date of enactment of this paragraph, on or after the date that is 1 year after such date of enactment.

(ii) CURRENT PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enactment, on or after the date that is 2 years after such date of enactment.

(iii) REVALIDATION OF ENROLLMENT.—Effective beginning on the date that is 180 days after such date of enactment, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this title, title XIX, or title XXI.

(iv) LIMITATION ON ENROLLMENT AND REVALIDATION OF ENROLLMENT.—In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this title,

title XIX, or title XXI on or after the date that is 3 years after such date of enactment.

(E) USE OF INFORMATION FROM THE DEPARTMENT OF TREASURY CONCERNING TAX DEBTS.—In reviewing the application of a provider of services or supplier to enroll or reenroll under the program under this title, the Secretary shall take into account the information supplied by the Secretary of the Treasury pursuant to section 6103(l)(22) of the Internal Revenue Code of 1986, in determining whether to deny such application or to apply enhanced oversight to such provider of services or supplier pursuant to paragraph (3) if the Secretary determines such provider of services or supplier owes such a debt.

(F) EXPEDITED RULEMAKING.—The Secretary may promulgate an interim final rule to carry out this paragraph.

(3) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND SUPPLIERS.—

(A) IN GENERAL.—The Secretary shall establish procedures to provide for a provisional period of not less than 30 days and not more than 1 year during which new providers of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as prepayment review and payment caps, under the program under this title, the Medicaid program under title XIX. and the CHIP program under title XXI.

(B) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

(4) 90-DAY PERIOD OF ENHANCED OVERSIGHT FOR INITIAL CLAIMS OF DME SUPPLIERS.—For periods beginning after January 1, 2011, if the Secretary determines that there is a significant risk of fraudulent activity among suppliers of durable medical equipment, in the case of a supplier of durable medical equipment who is within a category or geographic area under title XVIII identified pursuant to such determination and who is initially enrolling under such title, the Secretary shall, notwithstanding sections 1816(c), 1842(c), and 1869(a)(2), withhold payment under such title with respect to durable medical equipment furnished by such supplier during the 90-day period beginning on the date of the first submission of a claim under such title for durable medical equipment *furnished* by such supplier.

(5) INCREASED DISCLOSURE REQUIREMENTS.—

(A) DISCLOSURE.—A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in the program under this title, title XIX, or title XXI on or after the date that is 1 year after the date of enactment of this paragraph shall disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspen-

sion under a Federal health care program (as defined in section 1128B(f)), has been excluded from participation under the program under this title, the Medicaid program under title XIX, or the CHIP program under title XXI, or has had its billing privileges denied or revoked.

(B) AUTHORITY TO DENY ENROLLMENT.—If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

(6) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR MEDICARE OBLIGATIONS.—

(A) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this title in order to satisfy any amount described in subparagraph (B)(ii) due from such obligated provider of services or supplier.

(B) DEFINITIONS.—In this paragraph:

(i) IN GENERAL.—The term "applicable provider of services or supplier" means a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program under this title than is assigned to the obligated provider of services or supplier.

(ii) OBLIGATED PROVIDER OF SERVICES OR SUPPLIER.—The term "obligated provider of services or supplier" means a provider of services or supplier that owes an amount that is more than the amount required to be paid under the program under this title (as determined by the Secretary).

(7) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS; NONPAYMENT.—

(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under the CHIP program under title XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

(B) LIMITATION ON REVIEW.—There shall be no judicial review under section 1869, section 1878, or otherwise, of a temporary moratorium imposed under subparagraph (A).

(C) NONPAYMENT.—

(i) IN GENERAL.—No payment may be made under this title or under a program described in subpara-

graph (A) with respect to an item or service described in clause (ii) furnished on or after October 1, 2017.

(ii) ITEM OR SERVICE DESCRIBED.—An item or service described in this clause is an item or service furnished—

(I) within a geographic area with respect to which a temporary moratorium imposed under subparagraph (A) is in effect; and

(II) by a provider of services or supplier that meets the requirements of clause (iii).

(iii) REQUIREMENTS.—For purposes of clause (ii), the requirements of this clause are that a provider of services or supplier—

(I) enrolls under this title on or after the effective date of such temporary moratorium; and

(II) is within a category of providers of services and suppliers (as described in subparagraph (A)) subject to such temporary moratorium.

(iv) PROHIBITION ON CHARGES FOR SPECIFIED ITEMS OR SERVICES.—In no case shall a provider of services or supplier described in clause (ii)(II) charge an individual or other person for an item or service described in clause (ii) furnished on or after October 1, 2017, to an individual entitled to benefits under part A or enrolled under part B or an individual under a program specified in subparagraph (A).

(8) COMPLIANCE PROGRAMS.—

(A) IN GENERAL.—On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.

(9) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll

(or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

(k) QUALITY REPORTING BY CANCER HOSPITALS.—

(1) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

(2) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(3) QUALITY MEASURES.—

(A) IN GENERAL.—Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1890(a).

(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(C) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

(4) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

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COMMITTEE CORRESPONDENCE

FRANK PALLONE, JR., NEW JERSEY
CHAIRMAN

CATHY McMORRIS RODGERS, WASHINGTON
RANKING MEMBER

ONE HUNDRED SEVENTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

March 26, 2021

The Honorable Bobby Scott
Chairman
Committee on Education and Labor
2176 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Scott:

I write concerning H.R. 1195, the "Workplace Violence Prevention for Health Care and Social Service Workers Act," which was additionally referred to the Committee on Energy and Commerce.

In recognition of the desire to expedite consideration of H.R. 1195, the Committee on Energy and Commerce agrees to waive formal consideration of the bill as to provisions that fall within the rule X jurisdiction of the Committee on Energy and Commerce. The Committee takes this action with the mutual understanding that we do not waive any jurisdiction over the subject matter contained in this or similar legislation, and that the Committee will be appropriately consulted and involved as this bill or similar legislation moves forward so that we may address any remaining issues within our jurisdiction. I also request that you support my request to name members of the Committee on Energy and Commerce to any conference committee to consider such provisions.

Finally, I would appreciate the inclusion of this letter in the report on the bill and into the *Congressional Record* during floor consideration of H.R. 1195.

Sincerely,

Frank Pallone, Jr.

Frank Pallone, Jr.
Chairman

cc. The Honorable Nancy Pelosi, Speaker
The Honorable Steny Hoyer, Majority Leader
The Honorable Cathy McMorris Rodgers, Ranking Member, Committee on Energy and Commerce
The Honorable Virginia Foxx, Ranking Member, Committee on Education and Labor
The Honorable Jason Smith, Parliamentarian

March 26, 2021

The Honorable Frank Pallone, Jr.
Chairman
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone:

In reference to your letter of March 26, 2021, I write to confirm our mutual understanding regarding H.R. 1195, the "Workplace Violence Prevention for Health Care and Social Service Workers Act."

I appreciate the Committee on Energy and Commerce's waiver of consideration of H.R. 1195 as specified in your letter. I acknowledge that the waiver was granted only to expedite floor consideration of H.R. 1195 and does not in any way waive or diminish the Committee on Energy and Commerce's jurisdictional interests over this or similar legislation.

I would be pleased to include our exchange of letters on this matter in committee report for H.R. 1195 and in the *Congressional Record* during floor consideration of the bill to memorialize our joint understanding.

Again, thank you for your assistance with these matters.

Very truly yours,

Robert C. "Bobby" Scott
Chairman

cc: The Honorable Cathy McMorris Rodgers, Ranking Member, Committee on Energy and Commerce
The Honorable Virginia Foxx, Ranking Member, Committee on Education and Labor
The Honorable Nancy Pelosi, Speaker
The Honorable Steny Hoyer, Majority Leader
The Honorable Jason Smith, Parliamentarian

MINORITY VIEWS

INTRODUCTION

The health care and social services industries face a significant risk of workplace violence. The Bureau of Labor Statistics (BLS) reported these industries experience the highest rates of injuries caused by workplace violence. BLS also reported health care and social service workers in the private sector experienced workplace violence-related injuries at an estimated incidence rate of 10.4 per 10,000 full-time workers in 2018, and are five times more likely to suffer a workplace violence injury than other workers overall.[1] Committee Republicans are committed to responsible federal laws, regulations, and policies to ensure American workers are kept out of harm's way on the job so they can return home to their families every day healthy and safe.

However, H.R. 1195, the *Workplace Violence Prevention for Health Care and Social Service Workers Act,* is not the right solution to address workplace violence in the health care and social services industries. The legislation is overly prescriptive, limits the Occupational Safety and Health Administration's (OSHA) ability to draft an effective, workable, and feasible regulation, and imposes unwarranted shortcuts in the regulatory process that will deprive the agency of meaningful, vital stakeholder input. OSHA has recognized the hazards and risks health care and social service workers face and is moving forward with the rulemaking process to address these workplace safety concerns.[2] H.R. 1195 circumvents that process and will limit the agency's ability to write an effective and protective rule. Further, H.R. 1195's requirement that OSHA issue a rushed interim final standard within one year is particularly ill-timed and will be harmful to the health care industry, which is currently doing heroic work on the front lines in response to the COVID–19 pandemic.

Committee Republicans believe there is a bipartisan solution to this issue that would respect the rulemaking process and provide protection to health care and social service workers. However, by advancing H.R. 1195, the Committee majority is short-circuiting the regulatory process and choosing to push through overly prescriptive mandates without important and necessary stakeholder input. For these reasons, and as set forth more fully below, Committee Republicans are opposed to H.R. 1195.

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[1] BLS, INJURIES, ILLNESSES, AND FATALITIES: FACT SHEET WORKPLACE VIOLENCE IN HEALTHCARE, 2018 (Apr. 2020), https://www.bls.gov/iif/oshwc/cfoi/workplace-violence-healthcare-2018.htm.

[2] OFF. OF MGMT. & BUDGET, OFF. OF INFO. & REG. AFFAIRS, PREVENTION OF WORKPLACE VIOLENCE IN HEALTH CARE AND SOCIAL ASSISTANCE, REGULATORY AGENDA (2020).

CONCERNS WITH H.R. 1195

H.R. 1195 Neglects Important Regulatory Steps

H.R. 1195 requires OSHA to circumvent traditional and long-standing rulemaking procedures under the *Occupational Safety and Health Act of 1970* (OSH Act) and the *Administrative Procedure Act*. The bill compels OSHA to complete and issue an interim final standard within one year of enactment and with only one inadequate public comment period of 30 days prior to publication of the interim final standard. As such, H.R. 1195 severely limits the participation of industry, worker representatives, the scientific community, and the public in the development of a new, comprehensive standard governing a complex and highly technical area of workplace safety.

In 2015, then-Assistant Secretary of Occupational Safety and Heath David Michaels testified before the Committee outlining the important, necessary steps in developing a safety and health regulation:

> Developing OSHA regulations is a complex and long process, with extensive public consultation before any new standards are issued including, depending on the standard, requests for information, stakeholder meetings, *Small Business Regulatory Enforcement and Fairness Act* (SBREFA) panels, public hearings, and pre- and post-hearing comment periods. We are required by law to ensure that our standards are economically and technically feasible.[3]

H.R. 1195 forces the agency to skip these important steps by requiring that OSHA complete an interim final standard within one year. If the agency does not promulgate a standard within one year, the interim final standard goes into effect. Either way, the agency would be enforcing an interim final standard that lacks meaningful and essential public feedback. The regulatory steps Dr. Michaels outlined are necessary for a variety of important reasons including compelling the agency to receive important feedback from stakeholders and the public to create a protective, workable, and feasible federal safety and health standard.

One vital step the bill omits is the SBREFA panel. Eric Hobbs, an attorney with expertise in workplace safety and health, testified before the Committee in 2018 on the importance of this panel:

> Under the panel review process, small businesses who would be affected by a proposed regulation are allowed to review the draft proposal as well as OSHA's draft impact assessment and provide direct comments on them. This happens at a stage in the process when there is still time to make adjustments—unlike when, by contrast, a pro-

[3] *Protecting America's Workers: An Enforcement Update from the Occupational Safety and Health Administration: Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. & the Workforce*, 114th Cong. 11–12 (2015) (statement of David Michaels, Assistant Sec'y, Occupational Safety & Health Admin., U.S. Dep't of Lab.).

> posed regulation has been issued and there is very little chance to make significant changes.[4]

Notably, H.R. 1195 does not consider the impact of a workplace violence standard on small businesses and it does not require an economic impact test to determine whether it will have a significant effect on small businesses and if there are ways to minimize the impact. The regulatory steps to create a federal safety and health standard are vital to ensure the scope of the standard is appropriate, as small businesses may not have the same risk of workplace violence, or the same challenges, as larger employers. During the Obama administration, OSHA stated in its 2016 request for information (RFI) on prevention of workplace violence for health care and social assistance that the agency would consider the impacts on small businesses: 'Regardless of the significance of the impacts, OSHA seeks ways of minimizing the burdens of small businesses consistent with OSHA's statutory and regulatory requirements and objectives."[5]

In a 2021 letter to the Committee, the American Hospital Association expressed concerns about omitting important regulatory steps:

> [B]ecause hospitals have already implemented specifically tailored policies and programs to address workplace violence, we do not believe that the OSHA standards required by H.R. 1195 are warranted, nor do we support an expedited approach that would deny the public the opportunity to review and comment on proposed regulations.[6]

H.R. 1195 also discounts the expertise of American workers who have experienced workplace violence and who could provide important insights, as well as a variety of experts who have been researching the issue for years. Mr. Manesh Rath, an attorney with experience in occupational safety and health law and administrative law, explained in Committee testimony in 2019 when nearly identical legislation[7] was considered, that mitigating workplace violence is a subject area in which stakeholders have amassed critical knowledge and experience that would be important to consider during rulemaking:

> Any effort to regulate the issue of workplace violence in healthcare should be thoughtful rather than rushed. The process should be inclusive of employers, employees, the security industry, the insurance industry, and the scientific and medical professions. This subcommittee can and should have faith that the collaborative input of those

[4] *A More Effective and Collaborative OSHA: A View from Stakeholders: Hearing before the Subcomm. on Workforce Protections of the H. Comm. on Educ. & the Workforce,* 115th Cong. (2018) (written statement of Eric Hobbs, Shareholder, Ogletree, Deakins, at 4).

[5] Prevention of Workplace Violence for Healthcare and Social Assistance, 81 Fed. Reg. 88,147, 88,164 (Dec. 7, 2016) (request for information).

[6] *Letter* from Thomas Nickels, Exec. Vice President, Am. Hosp. Ass'n, to Rep. Joe Courtney (Mar. 23, 2021) (on file).

[7] H.R. 1309, 116th Cong. (2019).

with experience, training, and learning in this field will yield a better approach than the Bill before us today.[8]

OSHA is Currently Enforcing Workplace Violence Prevention

Starting in the Obama administration and continuing through the Trump administration, OSHA has enforced workplace violence prevention under the general duty clause, section 5(a)(1) of the OSH Act.[9] Additionally, in 2017, OSHA issued an enforcement directive on conducting investigations and citations related to occupational exposure to workplace violence.[10] Allowing OSHA to complete a comprehensive rulemaking process—rather than requiring a rushed, corner cutting approach mandated by H.R. 1195—will not leave the health care and social services industry sectors without proper enforcement.

For example, in 2019, the Occupational Safety and Health Review Commission (OSHRC) upheld penalties issued by OSHA under the general duty clause against health care facilities for not adequately addressing workplace violence. Covette Rooney, the chief administrative law judge of OSHRC, stated in her decision and order:

> There is no specific OSHA standard addressing the hazard of workplace violence. This does not mean that employers have no obligation to address the hazard. Rather, if an employer or its industry recognize that workplace violence is an actual or potential hazard that can cause death or serious physical harm, the Act's general duty clause requires such employers to act to eliminate or materially reduce this hazard.[11]

This OSHRC decision, which has been subsequently upheld by the U.S. Court of Appeals for the District of Columbia Circuit,[12] confirms OSHA's authority and intent to enforce workplace violence protections under the general duty clause, obviating the purported need to rush a standard through the regulatory process.

H.R. 1195 is Unreasonably and Unnecessarily Prescriptive

H.R. 1195 requires OSHA to base its interim final standard on the 2015 OSHA "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers."[13] These guidelines, now outdated, were based on best practices and feedback from stakeholders at the time. However, the interim final standard as prescribed by H.R. 1195 will not consider any data or lessons that have been learned since 2015 that are contrary to the 2015 guidance. H.R. 1195 thus disadvantages the very workers it purports

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[8] *Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence: Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. & Labor,* 116th Cong. 29 (2019) (statement of Manesh Rath, Partner, Keller & Heckman LLP).

[9] 29 U.S.C. § 654.

[10] OSHA, DIR. NO. CPL 02-01-058, ENFORCEMENT PROCEDURES AND SCHEDULING FOR OCCUPATIONAL EXPOSURE TO WORKPLACE VIOLENCE (2017).

[11] BHC Northwest Psychiatric Hosp., OSHRC No. 17-0063 (Jan. 22, 2019) (decision and order).

[12] BHC Nw. Psychiatric Hosp. v. Sec'y of Lab., 951 F.3d 558 (D.C. Cir. 2020).

[13] Workplace Violence Prevention for Health Care and Social Service Workers Act, H.R. 1195, 117th Cong. § 101(a)(1)(B) (2021).

to help by ignoring important feedback and evidence that is currently available. Mr. Rath stated in his testimony:

> Before proceeding to rulemaking to develop a legally binding standard, OSHA should review its experience with the guidance issued on workplace violence and what has been learned from citing employers for workplace violence hazards under the General Duty Clause.[14]

Moreover, in 2016, OSHA published an RFI on "Workplace Violence Prevention for Health Care and Social Assistance," but H.R. 1195 does not incorporate information and findings from the comments received by OSHA responding to the RFI.[15] The sole purpose of an RFI is to gather data and information to help determine the appropriate next steps in a rulemaking process; H.R. 1195 disregards this important step.

In considering rulemaking at the federal level, past experiences should always inform the most effective solution. In 2016, California issued a regulation titled "Violence Prevention in Health Care," which went into full effect in April 2018.[16] When considering a far-reaching federal regulation on workplace violence prevention, it would be irresponsible not to review and study the California policy's impact on the regulated community. However, H.R. 1195 requires the final standard provide no less protection than any standard adopted by a state plan provided that the Secretary of Labor "finds that the final standard is feasible on the basis of best available evidence."[17] Bottom line, H.R. 1195 requires OSHA to default to California's standard unless the agency can show that it is not feasible.

H.R. 1195 does not take into consideration that California's standard may not be an effective or workable approach in California and may be the wrong solution if imposed nationwide. Mr. Rath noted in testimony before the Committee in the 117th Congress that California's recent, hastily approved emergency standard on COVID–19 has notable legal and procedural deficiencies.[18] OSHA's 2016 RFI understood the importance of gathering information on state laws, stating: "OSHA is also interested in hearing about healthcare facilities" experiences with provisions of state laws that have been shown to be effective in some way."[19]

H.R. 1195 Lacks Needed Research and Data

Committee Democrats have failed to provide the needed foundation for the workplace violence prevention standard required by H.R. 1195. Regulation of workplace violence prevention in the health care and social services industries must be grounded in evidence-based research. Currently, there is no agreed-upon set of policies to prevent workplace violence, and researchers in the field have pointed to the need for additional studies.

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[14] Rath statement, *supra* note 8, at 26.
[15] Prevention of Workplace Violence for Healthcare and Social Assistance, *supra* note 5.
[16] Cal. Code of Regs. tit. 8 §3342.
[17] H.R. 1195, 117th Cong. §101(b)(2)(A).
[18] *Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections: Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. & Lab.*, 117th Cong. (2021) (statement of Manesh Rath, Partner, Keller & Heckman LLP, at 4).
[19] Prevention of Workplace Violence for Healthcare and Social Assistance, *supra* note 5, at 88,152.

The Centers for Disease Control and Prevention published its "National Occupational Research Agenda for Healthcare and Social Assistance" in February 2019. The research agenda was developed to identify the knowledge and actions most urgently needed to improve safety in the industry. The 2019 agenda included an objective to "investigate the epidemiology of workplace violence in health care and identify effective strategies for prevention and mitigation." The objective points to the following concerns regarding needed research on the topic:

> Many existing studies have evaluated workplace violence risk factors and prevention measures, but most lack the comprehensive, facility- and work area-specific perspective that is needed to effectively prevent workplace violence. Additionally, many of these studies examine the effects of training programs, showing little impact on workplace violence incident and injury rates.[20]

Even the 2016 report by the Government Accountability Office (GAO), cited by supporters of H.R. 1195, highlights there have been a limited number of studies on the effectiveness of workplace violence prevention, stating: "Relatively few studies have been conducted on the effectiveness of workplace violence prevention programs, limiting what is known about the extent to which such programs or their components reduce workplace violence."[21] Moreover, the 2016 GAO report did not call on OSHA to promulgate a standard; instead, it recommended a full assessment of OSHA's efforts to address workplace violence in health care facilities:

> [OSHA should a]ssess the results of its efforts to determine whether additional action, such as development of a standard may be needed. OSHA has not fully assessed the results of its efforts to address workplace violence in health care facilities. Without assessing these results, OSHA will not be in a position to know whether its efforts are effective or if additional action may be needed to address this hazard.[22]

Following GAO's recommendation, as noted previously, OSHA issued an RFI to gather more data from the public to better understand how to proceed, stating:

> OSHA is interested in hearing from employers and individuals in facilities that provide healthcare and social assistance about their experience with the various components of workplace violence prevention programs that are currently being implemented by their facilities.[23]

However, the RFI was only a first step for OSHA in gathering important information on workplace violence prevention, and the agency clearly believed additional data was needed before pro-

[20] CTRS. FOR DISEASE CONTROL & PREVENTION, NATIONAL OCCUPATIONAL RESEARCH AGENDA FOR HEALTHCARE AND SOCIAL ASSISTANCE 13 (Feb. 2019).
[21] U.S. GOV'T ACCOUNTABILITY OFF., GAO–16–11, WORKPLACE SAFETY AND HEALTH: ADDITIONAL EFFORTS NEEDED TO HELP PROTECT HEALTH CARE WORKERS FROM WORKPLACE VIOLENCE 1 (Mar. 2016).
[22] *Id.*
[23] Prevention of Workplace Violence for Healthcare and Social Assistance, *supra* note 5, at 88,161.

ceeding. Members of the health care and social assistance research communities have identified workplace violence prevention as an area in need of further examination, yet the Committee majority is pushing through a standard that lacks meaningful expert input and stakeholder participation.

H.R. 1195 Will Harm Health Care Facilities During the COVID–19 Pandemic

Over the past year, the health care industry has made heroic efforts on the front lines, responding to the COVID–19 pandemic. Health care facilities have invested significant resources during the pandemic to prepare and effectively care for a surge of COVID–19 patients and maintain a safe workplace for their employees to protect them from the virus. H.R. 1195's mandate that OSHA issue an interim final rule on workplace violence in the health care and social services industries within one year is incredibly ill-timed amidst the ongoing pandemic and will significantly strain health care facilities at a time when resources have rightly been prioritized to respond to the most significant public health threat the United States has experienced in a century. The impact will especially be felt by medical facilities in rural areas and other vulnerable communities with scarce resources, which are already at risk of closure.[24]

When nearly identical legislation was considered in the 116th Congress prior to the COVID–19 pandemic, the Congressional Budget Office (CBO) estimated that enactment would result in compliance costs of at least $1.8 billion for private facilities and $100 million for public facilities over the first two years the rule prescribed by this legislation would be in effect.[25] CBO estimated that in the long term, combined compliance costs for the private and public sectors would run at least $805 million annually, and substantial personnel and capital costs would be imposed by the requirements for employee education, investigation, engineering controls, and infrastructure changes. Of the CBO's projected cost burden of Committee Democrats' legislation, the American Hospital Association stated:

> Such costs are unsustainable. A recent report by Kaufman-Hall forecasts that total hospital revenue in 2021 could be down between $53 billion and $122 billion from pre-pandemic levels. In addition to lost revenue, hospitals must absorb increases in many expenses due to COVID–19. These losses come on top of the historic financial crisis that hit the hospital field last year, with an AHA report estimating total losses for the nation's hospitals and health systems to be at least $323 billion through 2020.[26]

In addition, on January 21, 2021, President Biden issued an Executive Order (EO) on "Protecting Worker Safety and Health," which directed OSHA to consider whether an emergency temporary

[24] U.S. GOV'T ACCOUNTABILITY OFF., GAO–121–93, RURAL HOSPITAL CLOSURES: AFFECTED RESIDENTS HAD REDUCED ACCESS TO HEALTH CARE SERVICES (Dec. 2020).
[25] CBO, H.R. 1309, WORKPLACE VIOLENCE PREVENTION FOR HEALTH CARE AND SOCIAL SERVICE WORKERS ACT (NOV. 19, 2019).
[26] Letter from Thomas Nickels, *supra* note 6.

standard (ETS) to protect workers from COVID–19 is necessary.[27] The agency has already missed the March 15 deadline prescribed by President Biden's EO and has not yet determined whether an ETS is necessary. If OSHA issues a sweeping emergency regulation on COVID–19 on top of an interim final rule on workplace violence within one year, as required by H.R. 1195, this regulatory onslaught will significantly burden the health care industry and have a devastating impact on its ability to respond to the ongoing COVID–19 pandemic.

H.R. 1195 Inappropriately Imposes a New Government Enforcement Regime on Employers

It is important to protect employees from retaliation for reporting a violent incident or injury to their employer. That is why under section 11(c) of the OSH Act, employees have the right to pursue complaints alleging retaliation.[28] However, H.R. 1195 allows government bureaucrats to unilaterally investigate what they believe is potential retaliation in the absence of an actual complaint. Employees are already protected from retaliation under current law, but H.R. 1195 radically expands OSHA's authority to investigate alleged retaliation without the existence of a whistleblower complaint.

H.R. 1195 Creates New Data Privacy Risks and Requires Unnecessary Annual Reporting to OSHA

Employers use records, such as violence incident logs and annual summaries, to improve internal management and processes to protect their workplaces. Additionally, OSHA inspectors have the right to review the records upon inspection of the facility.[29] However, if employers are required to submit these reports to OSHA annually, as H.R. 1195 mandates, then it will deter the use of the records for these purposes; the employer will have no guarantee the records will not be released either intentionally or unintentionally and used improperly. In a comment letter to OSHA regarding the proposed 2013 recordkeeping submittal requirement, the Coalition for Workplace Safety stated:

> Public disclosure of this information will lead to underreporting of injuries and illness, creating a problem that does not currently exist. And, it will allow those who wish to do so, to mischaracterize and misuse the information for reasons wholly unrelated to safety.[30]

It is important that facilities keep accurate records of incidents, responses to incidents, and annual data, but a government man-

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[27] Exec. Order No. 13,999, 86 Fed. Reg. 7211 (Jan. 26, 2021).

[28] 29 U.S.C. § 660(c); OSHA's 2015 "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers," states:

Reprisal or discrimination against an employee for reporting an incident or injury related to workplace violence, related to this guidance, to an employer or OSHA would constitute a violation of Section 11(c) of the Act. In addition, 29 CFR 1904.36 provides that Section 11(c) of the Act prohibits discrimination against an employee for reporting a work related fatality, injury or illness.

[29] 29 U.S.C. § 657.

[30] Letter from Coalition for Workplace Safety to David Michaels, Assistant Sec'y, Occupational Safety & Health Admin., U.S. Dep't of Labor (Mar. 10, 2014), https://www.regulations.gov/document?D=OSHA-2013-0023-1411.

date requiring employers to provide this information to OSHA annually will not produce greater safety benefits.

REPUBLICAN SUBSTITUTE

Committee Republicans are committed to ensuring that health care and social service workers are protected from workplace violence and are supportive of OSHA's efforts to promulgate a rule on workplace violence prevention. However, Congress should aid in the rulemaking process and not circumvent it.

To achieve these goals, Representative Tim Walberg (R–MI) offered a substitute amendment at the Committee markup that requires the Secretary of Labor to promulgate a final standard on workplace violence prevention for health care and social services sectors but allows OSHA to follow the proper rulemaking procedures and ultimately be responsive to public comments. The amendment strikes the requirement to publish an interim final standard within an arbitrary deadline of one year. Instead, the amendment allows the agency to perform its due diligence to develop a standard based on meaningful and robust public comments. The amendment outlines principles of a workplace violence prevention standard and allows the agency to be responsive to experts and public concerns to produce the most protective and feasible standard.

Representative Walberg's amendment also requires that OSHA conduct an educational campaign on workplace violence prevention for health care and social services industries while it is engaged in rulemaking. The campaign will increase awareness of the issue, assisting with compliance and supporting wider participation in the rulemaking process. In addition, when OSHA promulgates the workplace violence prevention standard, the amendment requires the agency to conduct an educational campaign for covered employees and employers on the requirements of the standard.

The amendment removes the annual reporting requirement of workplace violence data to OSHA, does not allow government-initiated anti-retaliation investigations that are not based on a complaint, and maintains the current anti-retaliation provision in the OSH Act. Unfortunately, Committee Democrats, by unanimously opposing this commonsense amendment, chose to prejudge and impose a prescriptive solution without allowing for meaningful stakeholder input, which will result in a flawed regulatory approach.

CONCLUSION

H.R. 1195 will result in a hasty and flawed regulation that ignores expert and practical input and imposes overly prescriptive mandates that will eliminate higher quality, more protective, and practical solutions. H.R 1195 blocks necessary public input that will produce a superior, feasible workplace violence prevention standard and imposes onerous requirements on employers without providing evidence to demonstrate that this punitive government intervention is needed or will work. For these reasons, and those outlined above, Committee Republicans oppose the enactment of H.R. 1195 as reported by the Committee on Education and Labor.

VIRGINIA FOXX,
Ranking Member.
JOE WILSON.
GLENN "GT" THOMPSON.
TIM WALBERG.
GLENN GROTHMAN.
RICK W. ALLEN.
JIM BANKS.
JAMES COMER.
RUSS FULCHER.
FRED KELLER.
BURGESS OWENS.
LISA C. MCCLAIN.
DIANA HARSHBARGER.
SCOTT FITZGERALD.
MADISON CAWTHORN.

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Code of Federal Regulations

Title 45 - Public Welfare

Volume: 2
Date: 2020-10-01
Original Date: 2020-10-01
Title: Section Â§ 164.512 - Uses and disclosures for which an authorization or opportunity to agree or object is not required.
Context: Title 45 - Public Welfare. Subtitle A - Department of Health and Human Services. SUBCHAPTER C - ADMINISTRATIVE DATA STANDARDS AND RELATED REQUIREMENTS. PART 164 - SECURITY AND PRIVACY. Subpart E - Privacy of Individually Identifiable Health Information.

§ 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.

A covered entity may use or disclose protected health information without the written authorization of the individual, as described in § 164.508, or the opportunity for the individual to agree or object as described in § 164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally.

(a) *Standard: Uses and disclosures required by law.* (1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

(2) A covered entity must meet the requirements described in paragraph (c), (e), or (f) of this section for uses or disclosures required by law.

(b) *Standard: Uses and disclosures for public health activities* —(1) *Permitted uses and disclosures.* A covered entity may use or disclose protected health information for the public health activities and purposes described in this paragraph to:

(i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;

(ii) A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

(iii) A person subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity. Such purposes include:

(A) To collect or report adverse events (or similar activities with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations;

(B) To track FDA-regulated products;

(C) To enable product recalls, repairs, or replacement, or lookback (including locating and notifying individuals who have received products that have been recalled, withdrawn, or are the subject of lookback); or

(D) To conduct post marketing surveillance;

(iv) A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation; or

(v) An employer, about an individual who is a member of the workforce of the employer, if:

(A) The covered entity is a covered health care provider who provides health care to the individual at the request of the employer:

(*1*) To conduct an evaluation relating to medical surveillance of the workplace; or

(*2*) To evaluate whether the individual has a work-related illness or injury;

(B) The protected health information that is disclosed consists of findings concerning a work-related illness or injury or a workplace-related medical surveillance;

(C) The employer needs such findings in order to comply with its obligations, under 29 CFR parts 1904 through 1928, 30 CFR parts 50 through 90, or under state law having a similar purpose, to record such illness or injury or to carry out responsibilities for workplace medical surveillance; and

(D) The covered health care provider provides written notice to the individual that protected health information relating to the medical surveillance of the workplace and work-related illnesses and injuries is disclosed to the employer:

(*1*) By giving a copy of the notice to the individual at the time the health care is provided; or

(*2*) If the health care is provided on the work site of the employer, by posting the notice in a prominent place at the location where the health care is provided.

(vi) A school, about an individual who is a student or prospective student of the school, if:

(A) The protected health information that is disclosed is limited to proof of immunization;

(B) The school is required by State or other law to have such proof of immunization prior to admitting the individual; and

(C) The covered entity obtains and documents the agreement to the disclosure from either:

(*1*) A parent, guardian, or other person acting *in loco parentis* of the individual, if the individual is an unemancipated minor; or

(*2*) The individual, if the individual is an adult or emancipated minor.

(2) *Permitted uses.* If the covered entity also is a public health authority, the covered entity is permitted to use protected health information in all cases in which it is permitted to disclose such information for public health activities under paragraph (b)(1) of this section.

(c) *Standard: Disclosures about victims of abuse, neglect or domestic violence* —(1) *Permitted disclosures.* Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) *Informing the individual.* A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing

such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(d) *Standard: Uses and disclosures for health oversight activities* —(1) *Permitted disclosures.* A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

(i) The health care system;

(ii) Government benefit programs for which health information is relevant to beneficiary eligibility;

(iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or

(iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.

(2) *Exception to health oversight activities.* For the purpose of the disclosures permitted by paragraph (d)(1) of this section, a health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

(i) The receipt of health care;

(ii) A claim for public benefits related to health; or

(iii) Qualification for, or receipt of, public benefits or services when a patient's health is integral to the claim for public benefits or services.

(3) *Joint activities or investigations.* Nothwithstanding paragraph (d)(2) of this section, if a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity for purposes of paragraph (d) of this section.

(4) *Permitted uses.* If a covered entity also is a health oversight agency, the covered entity may use protected health information for health oversight activities as permitted by paragraph (d) of this section.

(e) *Standard: Disclosures for judicial and administrative proceedings* —(1) *Permitted disclosures.* A covered entity may disclose protected health information in the course of any judicial or administrative proceeding:

(i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; or

(ii) In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if:

(A) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iii) of this section, from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or

(B) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iv) of this section, from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of paragraph (e)(1)(v) of this section.

(iii) For the purposes of paragraph (e)(1)(ii)(A) of this section, a covered entity receives satisfactory assurances from a party seeking protected health information if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The party requesting such information has made a good faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail a notice to the individual's last known address);

(B) The notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal; and

(C) The time for the individual to raise objections to the court or administrative tribunal has elapsed, and:

(*1*) No objections were filed; or

(2) All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

(iv) For the purposes of paragraph (e)(1)(ii)(B) of this section, a covered entity receives satisfactory assurances from a party seeking protected health information, if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or

(B) The party seeking the protected health information has requested a qualified protective order from such court or administrative tribunal.

(v) For purposes of paragraph (e)(1) of this section, a qualified protective order means, with respect to protected health information requested under paragraph (e)(1)(ii) of this section, an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

(A) Prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested; and

(B) Requires the return to the covered entity or destruction of the protected health information (including all copies made) at the end of the litigation or proceeding.

(vi) Notwithstanding paragraph (e)(1)(ii) of this section, a covered entity may disclose protected health information in response to lawful process described in paragraph (e)(1)(ii) of this section without receiving satisfactory assurance under paragraph (e)(1)(ii)(A) or (B) of this section, if the covered entity makes reasonable efforts to provide notice to the individual sufficient to meet the requirements of paragraph (e)(1)(iii) of this section or to seek a qualified protective order sufficient to meet the requirements of paragraph (e)(1)(v) of this section.

(2) *Other uses and disclosures under this section.* The provisions of this paragraph do not supersede other provisions of this section that otherwise permit or restrict uses or disclosures of protected health information.

(f) *Standard: Disclosures for law enforcement purposes.* A covered entity may disclose protected health information for a law enforcement purpose to a law enforcement official if the conditions in paragraphs (f)(1) through (f)(6) of this section are met, as applicable.

(1) *Permitted disclosures: Pursuant to process and as otherwise required by law.* A covered entity may disclose protected health information:

(i) As required by law including laws that require the reporting of certain types of wounds or other physical injuries, except for laws subject to paragraph (b)(1)(ii) or (c)(1)(i) of this section; or

(ii) In compliance with and as limited by the relevant requirements of:

(A) A court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;

(B) A grand jury subpoena; or

(C) An administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:

(1) The information sought is relevant and material to a legitimate law enforcement inquiry;

(2) The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and

(3) De-identified information could not reasonably be used.

(2) *Permitted disclosures: Limited information for identification and location purposes.* Except for disclosures required by law as permitted by paragraph (f)(1) of this section, a covered entity may disclose protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that:

(i) The covered entity may disclose only the following information:

(A) Name and address;

(B) Date and place of birth;

(C) Social security number;

 (D) ABO blood type and rh factor;

(E) Type of injury;

(F) Date and time of treatment;

(G) Date and time of death, if applicable; and

(H) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

(ii) Except as permitted by paragraph (f)(2)(i) of this section, the covered entity may not disclose for the purposes of identification or location under paragraph (f)(2) of this section any protected health information related to the individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue.

(3) *Permitted disclosure: Victims of a crime.* Except for disclosures required by law as permitted by paragraph (f)(1) of this section, a covered entity may disclose protected health information in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime, other than disclosures that are subject to paragraph (b) or (c) of this section, if:

(i) The individual agrees to the disclosure; or

(ii) The covered entity is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, provided that:

(A) The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;

(B) The law enforcement official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and

(C) The disclosure is in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(4) *Permitted disclosure: Decedents.* A covered entity may disclose protected health information about an individual who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the individual if the covered entity has a suspicion that such death may have resulted from criminal conduct.

(5) *Permitted disclosure: Crime on premises.* A covered entity may disclose to a law enforcement official protected health information that the covered entity believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity.

(6) *Permitted disclosure: Reporting crime in emergencies.* (i) A covered health care provider providing emergency health care in response to a medical emergency, other than such emergency on the premises of the covered health care provider, may disclose protected health information to a law enforcement official if such disclosure appears necessary to alert law enforcement to:

(A) The commission and nature of a crime;

(B) The location of such crime or of the victim(s) of such crime; and

(C) The identity, description, and location of the perpetrator of such crime.

(ii) If a covered health care provider believes that the medical emergency described in paragraph (f)(6)(i) of this section is the result of abuse, neglect, or domestic violence of the individual in need of emergency health care, paragraph (f)(6)(i) of this section does not apply and any disclosure to a law enforcement official for law enforcement purposes is subject to paragraph (c) of this section.

(g) *Standard: Uses and disclosures about decedents* —(1) *Coroners and medical examiners.* A covered entity may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. A covered entity that also performs the duties of a coroner or medical examiner may use protected health information for the purposes described in this paragraph.

(2) *Funeral directors.* A covered entity may disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary for funeral directors to carry out their duties, the covered entity may disclose the protected health information prior to, and in reasonable anticipation of, the individual's death.

(h) *Standard: Uses and disclosures for cadaveric organ, eye or tissue donation purposes.* A covered entity may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

(i) *Standard: Uses and disclosures for research purposes* —(1) *Permitted uses and disclosures.* A covered entity may use or disclose protected health information for research, regardless of the source of funding of the research, provided that:

(i) *Board approval of a waiver of authorization.* The covered entity obtains documentation that an alteration to or waiver, in whole or in part, of the individual authorization required by § 164.508 for use or disclosure of protected health information has been approved by either:

(A) An Institutional Review Board (IRB), established in accordance with 7 CFR lc.107, 10 CFR 745.107, 14 CFR 1230.107, 15 CFR 27.107, 16 CFR 1028.107, 21 CFR 56.107, 22 CFR 225.107, 24 CFR 60.107, 28 CFR 46.107, 32 CFR 219.107, 34 CFR 97.107, 38 CFR 16.107, 40 CFR 26.107, 45 CFR 46.107, 45 CFR 690.107, or 49 CFR 11.107; or

(B) A privacy board that:

(*1*) Has members with varying backgrounds and appropriate professional competency as necessary to review the effect of the research protocol on the individual's privacy rights and related interests;

(*2*) Includes at least one member who is not affiliated with the covered entity, not affiliated with any entity conducting or sponsoring the research, and not related to any person who is affiliated with any of such entities; and

(*3*) Does not have any member participating in a review of any project in which the member has a conflict of interest.

(ii) *Reviews preparatory to research.* The covered entity obtains from the researcher representations that:

(A) Use or disclosure is sought solely to review protected health information as necessary to prepare a research protocol or for similar purposes preparatory to research;

(B) No protected health information is to be removed from the covered entity by the researcher in the course of the review; and

(C) The protected health information for which use or access is sought is necessary for the research purposes.

(iii) *Research on decedent's information.* The covered entity obtains from the researcher:

(A) Representation that the use or disclosure sought is solely for research on the protected health information of decedents;

(B) Documentation, at the request of the covered entity, of the death of such individuals; and

(C) Representation that the protected health information for which use or disclosure is sought is necessary for the research purposes.

(2) *Documentation of waiver approval.* For a use or disclosure to be permitted based on documentation of approval of an alteration or waiver, under paragraph (i)(1)(i) of this section, the documentation must include all of the following:

(i) *Identification and date of action.* A statement identifying the IRB or privacy board and the date on which the alteration or waiver of authorization was approved;

(ii) *Waiver criteria.* A statement that the IRB or privacy board has determined that the alteration or waiver, in whole or in part, of authorization satisfies the following criteria:

(A) The use or disclosure of protected health information involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements;

(*1*) An adequate plan to protect the identifiers from improper use and disclosure;

(*2*) An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and

(*3*) Adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research study, or for

other research for which the use or disclosure of protected health information would be permitted by this subpart;

(B) The research could not practicably be conducted without the waiver or alteration; and

(C) The research could not practicably be conducted without access to and use of the protected health information.

(iii) *Protected health information needed.* A brief description of the protected health information for which use or access has been determined to be necessary by the institutional review board or privacy board, pursuant to paragraph (i)(2)(ii)(C) of this section;

(iv) *Review and approval procedures.* A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures, as follows:

(A) An IRB must follow the requirements of the Common Rule, including the normal review procedures (7 CFR 1c.108(b), 10 CFR 745.108(b), 14 CFR 1230.108(b), 15 CFR 27.108(b), 16 CFR 1028.108(b), 21 CFR 56.108(b), 22 CFR 225.108(b), 24 CFR 60.108(b), 28 CFR 46.108(b), 32 CFR 219.108(b), 34 CFR 97.108(b), 38 CFR 16.108(b), 40 CFR 26.108(b), 45 CFR 46.108(b), 45 CFR 690.108(b), or 49 CFR 11.108(b)) or the expedited review procedures (7 CFR 1c.110, 10 CFR 745.110, 14 CFR 1230.110, 15 CFR 27.110, 16 CFR 1028.110, 21 CFR 56.110, 22 CFR 225.110, 24 CFR 60.110, 28 CFR 46.110, 32 CFR 219.110, 34 CFR 97.110, 38 CFR 16.110, 40 CFR 26.110, 45 CFR 46.110, 45 CFR 690.110, or 49 CFR 11.110);

(B) A privacy board must review the proposed research at convened meetings at which a majority of the privacy board members are present, including at least one member who satisfies the criterion stated in paragraph (i)(1)(i)(B)(2) of this section, and the alteration or waiver of authorization must be approved by the majority of the privacy board members present at the meeting, unless the privacy board elects to use an expedited review procedure in accordance with paragraph (i)(2)(iv)(C) of this section;

(C) A privacy board may use an expedited review procedure if the research involves no more than minimal risk to the privacy of the individuals who are the subject of the protected health information for which use or disclosure is being sought. If the privacy board elects to use an expedited review procedure, the review and approval of the alteration or waiver of authorization may be carried out by the chair of the privacy board, or by one or more members of the privacy board as designated by the chair; and

(v) *Required signature.* The documentation of the alteration or waiver of authorization must be signed by the chair or other member, as designated by the chair, of the IRB or the privacy board, as applicable.

(j) *Standard: Uses and disclosures to avert a serious threat to health or safety* —(1) *Permitted disclosures.* A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:

(i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or

(ii) Is necessary for law enforcement authorities to identify or apprehend an individual:

(A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or

(B) Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody, as those terms are defined in § 164.501.

(2) *Use or disclosure not permitted.* A use or disclosure pursuant to paragraph (j)(1)(ii)(A) of this section may not be made if the information described in paragraph (j)(1)(ii)(A) of this section is learned by the covered entity:

(i) In the course of treatment to affect the propensity to commit the criminal conduct that is the basis for the disclosure under paragraph (j)(1)(ii)(A) of this section, or counseling or therapy; or

(ii) Through a request by the individual to initiate or to be referred for the treatment, counseling, or therapy described in paragraph (j)(2)(i) of this section.

(3) *Limit on information that may be disclosed.* A disclosure made pursuant to paragraph (j)(1)(ii)(A) of this section shall contain only the statement described in paragraph (j)(1)(ii)(A) of this section and the protected health information described in paragraph (f)(2)(i) of this section.

(4) *Presumption of good faith belief.* A covered entity that uses or discloses protected health information pursuant to paragraph (j)(1) of this section is presumed to have acted in good faith with regard to a belief described in paragraph (j)(1)(i) or (ii) of this section, if the belief is based upon the covered entity's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.

(k) *Standard: Uses and disclosures for specialized government functions* —(1) *Military and veterans activities* —(i) *Armed Forces personnel.* A covered entity may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the **Federal Register** the following information:

(A) Appropriate military command authorities; and

(B) The purposes for which the protected health information may be used or disclosed.

(ii) *Separation or discharge from military service.* A covered entity that is a component of the Departments of Defense or Homeland Security may disclose to the Department of Veterans Affairs (DVA) the protected health information of an individual who is a member of the Armed Forces upon the separation or discharge of the individual from military service for the purpose of a determination by DVA of the individual's eligibility for or entitlement to benefits under laws administered by the Secretary of Veterans Affairs.

(iii) *Veterans.* A covered entity that is a component of the Department of Veterans Affairs may use and disclose protected health information to components of the Department that determine eligibility for or entitlement to, or that provide, benefits under the laws administered by the Secretary of Veterans Affairs.

(iv) *Foreign military personnel.* A covered entity may use and disclose the protected health information of individuals who are foreign military personnel to their appropriate foreign military authority for the same purposes for which uses and disclosures are permitted for Armed Forces personnel under the notice published in the **Federal Register** pursuant to paragraph (k)(1)(i) of this section.

(2) *National security and intelligence activities.* A covered entity may disclose protected health information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act (50 U.S.C. 401, *et seq.*) and implementing authority (*e.g.,* Executive Order 12333).

(3) *Protective services for the President and others.* A covered entity may disclose protected health information to authorized Federal officials for the provision of protective services to the President or other persons authorized by 18 U.S.C. 3056 or to foreign heads of state or other persons authorized by 22 U.S.C. 2709(a)(3), or for the conduct of investigations authorized by 18 U.S.C. 871 and 879.

(4) *Medical suitability determinations.* A covered entity that is a component of the Department of State may use protected health information to make medical suitability determinations and may disclose whether or not the individual was determined to be medically suitable to the officials in the Department of State who need access to such information for the following purposes:

(i) For the purpose of a required security clearance conducted pursuant to Executive Orders 10450 and 12968;

(ii) As necessary to determine worldwide availability or availability for mandatory service abroad under sections 101(a)(4) and 504 of the Foreign Service Act; or

(iii) For a family to accompany a Foreign Service member abroad, consistent with section 101(b)(5) and 904 of the Foreign Service Act.

(5) *Correctional institutions and other law enforcement custodial situations* —(i) *Permitted disclosures.* A covered entity may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for:

(A) The provision of health care to such individuals;

(B) The health and safety of such individual or other inmates;

(C) The health and safety of the officers or employees of or others at the correctional institution;

(D) The health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another;

(E) Law enforcement on the premises of the correctional institution; or

(F) The administration and maintenance of the safety, security, and good order of the correctional institution.

(ii) *Permitted uses.* A covered entity that is a correctional institution may use protected health information of individuals who are inmates for any purpose for which such protected health information may be disclosed.

(iii) *No application after release.* For the purposes of this provision, an individual is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in lawful custody.

(6) *Covered entities that are government programs providing public benefits.* (i) A health plan that is a government program providing public benefits may disclose protected health information relating to eligibility for or enrollment in the health plan to another agency administering a government program providing public benefits if the sharing of eligibility or enrollment information among such government agencies or the maintenance of such information in a single or combined data system accessible to all such government agencies is required or expressly authorized by statute or regulation.

(ii) A covered entity that is a government agency administering a government program providing public benefits may disclose protected health information relating to the program to another covered entity that is a government agency administering a government program providing public benefits if the programs serve the same or similar populations and the disclosure of protected health information is necessary to coordinate the covered functions of such programs or to improve administration and management relating to the covered functions of such programs.

(7) *National Instant Criminal Background Check System.* A covered entity may use or disclose protected health information for purposes of reporting to the National Instant Criminal Background Check System the identity of an individual who is prohibited from possessing a firearm under 18 U.S.C. 922(g)(4), provided the covered entity:

(i) Is a State agency or other entity that is, or contains an entity that is:

(A) An entity designated by the State to report, or which collects information for purposes of reporting, on behalf of the State, to the National Instant Criminal Background Check System; or

(B) A court, board, commission, or other lawful authority that makes the commitment or adjudication that causes an individual to become subject to 18 U.S.C. 922(g)(4); and

(ii) Discloses the information only to:

(A) The National Instant Criminal Background Check System; or

(B) An entity designated by the State to report, or which collects information for purposes of reporting, on behalf of the State, to the National Instant Criminal Background Check System; and

(iii)(A) Discloses only the limited demographic and certain other information needed for purposes of reporting to the National Instant Criminal Background Check System; and

(B) Does not disclose diagnostic or clinical information for such purposes.

(l) *Standard: Disclosures for workers' compensation.* A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

[65 FR 82802, Dec. 28, 2000, as amended at 67 FR 53270, Aug. 14, 2002; 78 FR 5699, Jan. 25, 2013; 78 FR 34266, June 7, 2013; 81 FR 395, Jan. 6, 2016]

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§1711-C. Confidentiality of health care information

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Authorized representative of an individual" or "authorized representative" means an individual's legal guardian; agent pursuant to Title 18-C, section 5-803; agent pursuant to Title 18-C, Article 5, Part 9; or other authorized representative or, after death, that person's personal representative or a person identified in subsection 3-B. For a minor who has not consented to health care treatment in accordance with the provisions of state law, "authorized representative" means the minor's parent, legal guardian or guardian ad litem. [PL 2017, c. 402, Pt. C, §44 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

A-1. "Authorization to disclose" means authorization to disclose health care information in accordance with subsection 3, 3-A or 3-B. [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF).]

B. "Disclosure" means the release, transfer of or provision of access to health care information in any manner obtained as a result of a professional health care relationship between the individual and the health care practitioner or facility to a person or entity other than the individual. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. "Health care" means preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, treatment, procedures or counseling, including appropriate assistance with disease or symptom management and maintenance, that affects an individual's physical, mental or behavioral condition, including individual cells or their components or genetic information, or the structure or function of the human body or any part of the human body. Health care includes prescribing, dispensing or furnishing to an individual drugs, biologicals, medical devices or health care equipment and supplies; providing hospice services to an individual; and the banking of blood, sperm, organs or any other tissue. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. "Health care facility" or "facility" means a facility, institution or entity licensed pursuant to this Title that offers health care to persons in this State, including a home health care provider, hospice program and a pharmacy licensed pursuant to Title 32. For the purposes of this section, "health care facility" does not include a state mental health institute, the Elizabeth Levinson Center, the Aroostook Residential Center or Freeport Towne Square. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

E. "Health care information" means information that directly identifies the individual and that relates to an individual's physical, mental or behavioral condition, personal or family medical history or medical treatment or the health care provided to that individual. "Health care information" does not include information that protects the anonymity of the individual by means of encryption or encoding of individual identifiers or information pertaining to or derived from federally sponsored, authorized or regulated research governed by 21 Code of Federal Regulations, Parts 50 and 56 and 45 Code of Federal Regulations, Part 46, to the extent that such information is used in a manner that protects the identification of individuals. The Board of Directors of the Maine Health Data Organization shall adopt rules to define health care information that directly identifies an individual. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

"Health care information" does not include information that is created or received by a member of the clergy or other person using spiritual means alone for healing as provided in Title 32, sections

2103 and 3270. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F. "Health care practitioner" means a person licensed by this State to provide or otherwise lawfully providing health care or a partnership or corporation made up of those persons or an officer, employee, agent or contractor of that person acting in the course and scope of employment, agency or contract related to or supportive of the provision of health care to individuals. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

G. "Individual" means a natural person who is the subject of the health care information under consideration and, in the context of disclosure of health care information, includes the individual's authorized representative. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

H. "Third party" or "3rd party" means a person other than the individual to whom the health care information relates. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).] [PL 2017, c. 402, Pt. C, §44 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

2. Confidentiality of health information; disclosure. An individual's health care information is confidential and may not be disclosed other than to the individual by the health care practitioner or facility except as provided in subsection 3, 3-A, 3-B, 6 or 11. Nothing in this section prohibits a health care practitioner or health care facility from adhering to applicable ethical or professional standards provided that these standards do not decrease the protection of confidentiality granted by this section. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

3. Written authorization to disclose. A health care practitioner or facility may disclose health care information pursuant to a written authorization signed by an individual for the specific purpose stated in the authorization. A written authorization to disclose health care information must be retained with the individual's health care information. A written authorization to disclose is valid whether it is in an original, facsimile or electronic form. A written authorization to disclose must contain the following elements:

A. The name and signature of the individual and the date of signature. If the authorization is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date of signature; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

B. The types of persons authorized to disclose health care information and the nature of the health care information to be disclosed; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

C. The identity or description of the 3rd party to whom the information is to be disclosed; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

D. The specific purpose or purposes of the disclosure and whether any subsequent disclosures may be made pursuant to the same authorization. An authorization to disclose health care information related to substance use disorder treatment or care subject to the requirements of 42 United States Code, Section 290dd-2 (Supplement 1998) is governed by the provisions of that law; [PL 2017, c. 407, Pt. A, §72 (AMD).]

E. The duration of the authorization; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

F. A statement that the individual may refuse authorization to disclose all or some health care information but that refusal may result in improper diagnosis or treatment, denial of coverage or a

claim for health benefits or other insurance or other adverse consequences; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

G. A statement that the authorization may be revoked at any time by the individual by executing a written revocation, subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation, instructions on how to revoke an authorization and a statement that revocation may be the basis for denial of health benefits or other insurance coverage or benefits; and [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

H. A statement that the individual is entitled to a copy of the authorization form. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

[PL 2017, c. 407, Pt. A, §72 (AMD).]

3-A. Oral authorization to disclose. When it is not practical to obtain written authorization under subsection 3 from an individual or person acting pursuant to subsection 3-B or when a person chooses to give oral authorization to disclose, a health care practitioner or facility may disclose health care information pursuant to oral authorization. A health care practitioner or facility shall record with the individual's health care information receipt of oral authorization to disclose, including the name of the authorizing person, the date, the information and purposes for which disclosure is authorized and the identity or description of the 3rd party to whom the information is to be disclosed.

[PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

3-B. Authorization to disclose provided by a 3rd party. When an individual or an authorized representative is unable to provide authorization to disclose under subsection 3 or 3-A, a health care practitioner or facility may disclose health care information pursuant to authorization to disclose that meets the requirements of subsection 3 or 3-A given by a 3rd party listed in this subsection. A health care practitioner or facility may determine not to obtain authorization from a person listed in this subsection when the practitioner or facility determines it would not be in the best interest of the individual to do so. In making this decision, the health care practitioner or facility shall respect the safety of the individual and shall consider any indicators, suspicion or substantiation of abuse. Persons who may authorize disclosure under this subsection include:

A. The spouse of the individual; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

B. A parent of the individual; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. An adult who is a child, grandchild or sibling of the individual; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. An adult who is an aunt, uncle, niece or nephew of the individual, related by blood or adoption; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

E. An adult related to the individual, by blood or adoption, who is familiar with the individual's personal values; and [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F. An adult who has exhibited special concern for the individual and who is familiar with the individual's personal values. [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

[PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

4. Duration of authorization to disclose. An authorization to disclose may not extend longer than 30 months, except that the duration of an authorization for the purposes of insurance coverage under Title 24, 24-A or 39-A is governed by the provisions of Title 24, 24-A or 39-A, respectively.
[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

5. Revocation of authorization to disclose. A person who may authorize disclosure may revoke authorization to disclose at any time, subject to the rights of any person who acted in reliance on the authorization prior to receiving notice of revocation. A written revocation of authorization must be signed and dated. If the revocation is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date of signature. A health care practitioner or facility shall record receipt of oral revocation of authorization, including the name of the person revoking authorization and the date. A revocation of authorization must be retained with the authorization and the individual's health care information.
[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

6. Disclosure without authorization to disclose. A health care practitioner or facility may disclose, or when required by law must disclose, health care information without authorization to disclose under the circumstances stated in this subsection or as provided in subsection 11. Disclosure may be made without authorization as follows:

A. To another health care practitioner or facility for diagnosis, treatment or care of individuals or to complete the responsibilities of a health care practitioner or facility that provided diagnosis, treatment or care of individuals, as provided in this paragraph.

(1) For a disclosure within the office, practice or organizational affiliate of the health care practitioner or facility, no authorization is required.

(2) For a disclosure outside of the office, practice or organizational affiliate of the health care practitioner or facility, authorization is not required, except that in nonemergency circumstances authorization is required for health care information derived from mental health services provided by:

(a) A clinical nurse specialist licensed under the provisions of Title 32, chapter 31;

(b) A psychologist licensed under the provisions of Title 32, chapter 56;

(c) A social worker licensed under the provisions of Title 32, chapter 83;

(d) A counseling professional licensed under the provisions of Title 32, chapter 119; or

(e) A physician specializing in psychiatry licensed under the provisions of Title 32, chapter 36 or 48.

This subparagraph does not prohibit the disclosure of health care information between a licensed pharmacist and a health care practitioner or facility providing mental health services for the purpose of dispensing medication to an individual.

This subparagraph does not prohibit the disclosure without authorization of health care information covered under this section to a state-designated statewide health information exchange that satisfies the requirement in subsection 18, paragraph C of providing a general opt-out provision to an individual at all times and that provides and maintains an individual protection mechanism by which an individual may choose to opt in to allow the state-designated statewide health information exchange to disclose that individual's health care information covered under Title 34-B, section 1207.

This subparagraph does not prohibit the disclosure without authorization of health care information covered under this paragraph to a health care practitioner or health care facility, or to a payor or person engaged in payment for health care, for purposes of care management or coordination of care. Disclosure of psychotherapy notes is governed by 45 Code of Federal Regulations, Section 164.508(a)(2). A person who has made a disclosure under this subparagraph shall make a reasonable effort to notify the individual or the authorized representative of the individual of the disclosure; [PL 2013, c. 326, §1 (AMD).]

B. To an agent, employee, independent contractor or successor in interest of the health care practitioner or facility including a state-designated statewide health information exchange that makes health care information available electronically to health care practitioners and facilities or to a member of a quality assurance, utilization review or peer review team to the extent necessary to carry out the usual and customary activities relating to the delivery of health care and for the practitioner's or facility's lawful purposes in diagnosing, treating or caring for individuals, including billing and collection, risk management, quality assurance, utilization review and peer review. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales; [PL 2011, c. 347, §7 (AMD).]

C. To a family or household member unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. To appropriate persons when a health care practitioner or facility that is providing or has provided diagnosis, treatment or care to the individual in good faith believes that disclosure is made to avert a serious threat to health or safety and meets the conditions, as applicable, described in 45 Code of Federal Regulations, Section 164.512(j) (2012). A disclosure pursuant to this paragraph must protect the confidentiality of the health care information consistent with sound professional judgment; [PL 2013, c. 289, §1 (AMD).]

E. To federal, state or local governmental entities in order to protect the public health and welfare when reporting is required or authorized by law, to report a suspected crime against the health care practitioner or facility or to report information that the health care facility's officials or health care practitioner in good faith believes constitutes evidence of criminal conduct that occurred on the premises of the health care facility or health care practitioner; [PL 2011, c. 572, §1 (AMD).]

E-1. To federal, state or local governmental entities if the health care practitioner or facility that is providing diagnosis, treatment or care to an individual has determined in the exercise of sound professional judgment that the following requirements, as applicable, are satisfied:

(1) With regard to a disclosure for public health activities, for law enforcement purposes or that pertains to victims of abuse, neglect or domestic violence, the provisions of 45 Code of Federal Regulations, Section 164.512(b), (c) or (f) (2012) must be met; and

(2) With regard to a disclosure that pertains to a victim of domestic violence or a victim of sexual assault, the provisions of 45 Code of Federal Regulations, Section 164.512(c)(1)(iii)(A) (2012) and Section 164.512(c)(1)(iii)(B) (2012) must be met. [PL 2013, c. 289, §2 (NEW).]

E-2. To federal, state or local governmental entities if the health care practitioner or facility that is providing diagnosis, treatment or care to an individual has determined in the exercise of sound professional judgment that the disclosure is required by section 1727; [RR 2015, c. 1, §17 (COR).]

F. [PL 1999, c. 512, Pt. A, §5 (RP); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F-1. As directed by order of a court or as authorized or required by statute; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F-2. To a governmental entity pursuant to a lawful subpoena requesting health care information to which the governmental entity is entitled according to statute or rules of court; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F-3. **(TEXT EFFECTIVE ON CONTINGENCY: See PL 2013, c. 528, §12)** To the Maine Health Data Organization as required by and for use in accordance with chapter 1683. Health care information, including protected health information, as defined in 45 Code of Federal Regulations, Section 160.103 (2013), submitted to the Maine Health Data Organization must be protected by means of encryption; [PL 2013, c. 528, §1 (NEW); PL 2013, c. 528, §12 (AFF).]

G. To a person when necessary to conduct scientific research approved by an institutional review board or by the board of a nonprofit health research organization or when necessary for a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. A person conducting research or a clinical trial may not identify any individual patient in any report arising from the research or clinical trial. For the purposes of this paragraph, "institutional review board" means any board, committee or other group formally designated by a health care facility and authorized under federal law to review, approve or conduct periodic review of research programs. Health care information disclosed pursuant to this paragraph that identifies an individual must be returned to the health care practitioner or facility from which it was obtained or must be destroyed when it is no longer required for the research or clinical trial. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

H. To a person engaged in the assessment, evaluation or investigation of the provision of or payment for health care or the practices of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to statutory or professional standards or requirements. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

I. To a person engaged in the regulation, accreditation, licensure or certification of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to standards or requirements for regulation, accreditation, licensure or certification; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

J. To a person engaged in the review of the provision of health care by a health care practitioner or facility or payment for such health care under Title 24, 24-A or 39-A or under a public program for the payment of health care or professional liability insurance for a health care practitioner or facility or to an agent, employee or contractor of such a person; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

K. To attorneys for the health care practitioner or facility that is disclosing the health care information or to a person as required in the context of legal proceedings or in disclosure to a court or governmental entity, as determined by the practitioner or facility to be required for the practitioner's or facility's own legal representation; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

L. To a person outside the office of the health care practitioner or facility engaged in payment activities, including but not limited to submission to payors for the purposes of billing, payment, claims management, medical data processing, determination of coverage or adjudication of health benefit or subrogation claims, review of health care services with respect to coverage or justification of charges or other administrative services. Payment activities also include but are not limited to:

(1) Activities necessary to determine responsibility for coverage;

(2) Activities undertaken to obtain payment for health care provided to an individual; and

(3) Quality assessment and utilization review activities, including precertification and preauthorization of services and operations or services audits relating to diagnosis, treatment or care rendered to individuals by the health care practitioner or facility and covered by a health plan or other payor; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

M. To schools, educational institutions, youth camps licensed under section 2495, correctional facilities, health care practitioners and facilities, providers of emergency services or a branch of federal or state military forces, information regarding immunization of an individual; [PL 2009, c. 211, Pt. B, §17 (AMD).]

N. To a person when disclosure is needed to set or confirm the date and time of an appointment or test or to make arrangements for the individual to receive those services; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

O. To a person when disclosure is needed to obtain or convey information about prescription medication or supplies or to provide medication or supplies under a prescription; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

P. To a person representing emergency services, health care and relief agencies, corrections facilities or a branch of federal or state military forces, of brief confirmation of general health status; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

Q. To a member of the clergy, of information about the presence of an individual in a health care facility, including the person's room number, place of residence and religious affiliation unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

R. To a member of the media who asks a health care facility about an individual by name, of brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; [PL 2015, c. 370, §4 (AMD).]

S. To a member of the public who asks a health care facility about an individual by name, of the room number of the individual and brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; [PL 2017, c. 203, §2 (AMD).]

T. To a lay caregiver designated by an individual pursuant to section 1711-G; [PL 2021, c. 398, Pt. MMMM, §3 (AMD).]

U. To a panel coordinator of the maternal, fetal and infant mortality review panel pursuant to section 261, subsection 4, paragraph B-1 for the purposes of reviewing health care information of a deceased person and a mother of a child who died within one year of birth, including fetal deaths after 28 weeks of gestation. For purposes of this paragraph, "panel coordinator" has the same meaning as in section 261, subsection 1, paragraph E and "deceased person" has the same meaning as in section 261, subsection 1, paragraph B; and [PL 2021, c. 398, Pt. MMMM, §4 (AMD).]

V. To a panel coordinator of the Aging and Disability Mortality Review Panel pursuant to section 264, subsection 5, paragraph B, subparagraph (4) for the purposes of reviewing health care information of an adult receiving services who is deceased, in accordance with section 264, subsection 5, paragraph A. For purposes of this paragraph, "panel coordinator" has the same meaning as in section 264, subsection 2, paragraph B. [PL 2021, c. 398, Pt. MMMM, §5 (NEW).] [PL 2021, c. 398, Pt. MMMM, §§3-5 (AMD).]

7. Confidentiality policies. A health care practitioner, facility or state-designated statewide health information exchange shall develop and implement policies, standards and procedures to protect the confidentiality, security and integrity of health care information to ensure that information is not negligently, inappropriately or unlawfully disclosed. The policies of health care facilities must provide that an individual being admitted for inpatient care be given notice of the right of the individual to control the disclosure of health care information. The policies must provide that routine admission forms include clear written notice of the individual's ability to direct that that individual's name be removed from the directory listing of persons cared for at the facility and notice that removal may result in the inability of the facility to direct visitors and telephone calls to the individual.
[PL 2011, c. 373, §1 (AMD).]

8. Prohibited disclosure. A health care practitioner, facility or state-designated statewide health information exchange may not disclose health care information for the purpose of marketing or sales without written or oral authorization for the disclosure.
[PL 2011, c. 373, §2 (AMD).]

9. Disclosures of corrections or clarifications to health care information. A health care practitioner or facility shall provide to a 3rd party a copy of an addition submitted by an individual to the individual's health care information if:

A. The health care practitioner or facility provided a copy of the original health care record to the 3rd party on or after February 1, 2000; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

B. The correction or clarification was submitted by the individual pursuant to section 1711 or 1711-B and relates to diagnosis, treatment or care; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. The individual requests that a copy be sent to the 3rd party and provides an authorization that meets the requirements of subsection 3, 3-A or 3-B; and [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. If requested by the health care practitioner or facility, the individual pays to the health care practitioner or facility all reasonable costs requested by that practitioner or facility. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

10. Requirements for disclosures. Except as otherwise provided by law, disclosures of health care information pursuant to this section are subject to the professional judgment of the health care practitioner and to the following requirements.

A. A health care practitioner or facility that discloses health care information pursuant to subsection 3, 3-A or 3-B may not disclose information in excess of the information requested in the authorization. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

B. A health care practitioner or facility that discloses health care information pursuant to subsections 3, 3-A, 3-B or 6 may not disclose information in excess of the information reasonably required for the purpose for which it is disclosed. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. If a health care practitioner or facility believes that release of health care information to the individual would be detrimental to the health of the individual, the health care practitioner or facility shall advise the individual and make copies of the records available to the individual's authorized representative upon receipt of a written authorization. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

D. If a health care practitioner or facility discloses partial or incomplete health care information, as compared to the request or directive to disclose under subsection 3, 3-A, 3-B or 6, the disclosure must expressly indicate that the information disclosed is partial or incomplete. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

11. Health care information subject to other laws, rules and regulations. Health care information that is subject to the provisions of 42 United States Code, Section 290dd-2 (Supplement 1998); chapters 710-B and 711; Title 5, section 200-E; Title 5, chapter 501; Title 24 or 24-A; Title 34-B, section 1207; Title 39-A; or other provisions of state or federal law, rule or regulation is governed solely by those provisions.

[PL 2009, c. 387, §2 (AMD).]

12. Minors. If a minor has consented to health care in accordance with the laws of this State, authorization to disclose health care information pursuant to this section must be given by the minor unless otherwise provided by law.

[PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

13. Enforcement. This section may be enforced within 2 years of the date a disclosure in violation of this section was or should reasonably have been discovered.

A. When the Attorney General has reason to believe that a person has intentionally violated a provision of this section, the Attorney General may bring an action to enjoin unlawful disclosure of health care information. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

B. An individual who is aggrieved by conduct in violation of this section may bring a civil action against a person who has intentionally unlawfully disclosed health care information in the Superior Court in the county in which the individual resides or the disclosure occurred. The action may seek to enjoin unlawful disclosure and may seek costs and a forfeiture or penalty under paragraph C. An applicant for injunctive relief under this paragraph may not be required to give security as a condition of the issuance of the injunction. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. A person who intentionally violates this section is subject to a civil penalty not to exceed $5,000, payable to the State, plus costs. If a court finds that intentional violations of this section have occurred after due notice of the violating conduct with sufficient frequency to constitute a general business practice, the person is subject to a civil penalty not to exceed $10,000 for health care practitioners and $50,000 for health care facilities, payable to the State. A civil penalty under this subsection is recoverable in a civil action. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. Nothing in this section may be construed to prohibit a person aggrieved by conduct in violation of this section from pursuing all available common law remedies, including but not limited to an action based on negligence. [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

14. Waiver prohibited. Any agreement to waive the provisions of this section is against public policy and void.

[PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

15. Immunity. A cause of action in the nature of defamation, invasion of privacy or negligence does not arise against any person for disclosing health care information in accordance with this section.

This section provides no immunity for disclosing information with malice or willful intent to injure any person.
[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

16. Application. This section applies to all requests, directives and authorizations to disclose health care information executed on or after February 1, 2000. An authorization to disclose health care information executed prior to February 1, 2000 that does not meet the standards of this section is deemed to comply with the requirements of this section until the next health care encounter between the individual and the health care practitioner or facility.
[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

17. Repeal.
[PL 2001, c. 346, §1 (RP).]

18. Participation in a state-designated statewide health information exchange. The following provisions apply to participation in a state-designated statewide health information exchange.

A. A health care practitioner may not deny a patient health care treatment and a health insurer may not deny a patient a health insurance benefit based solely on the provider's or patient's decision not to participate in a state-designated statewide health information exchange. Except when otherwise required by federal law, a payor of health care benefits may not require participation in a state-designated statewide health information exchange as a condition of participating in the payor's provider network. [PL 2011, c. 691, Pt. A, §20 (RPR).]

B. Recovery for professional negligence is not allowed against any health care practitioner or health care facility on the grounds of a health care practitioner's or a health care facility's nonparticipation in a state-designated statewide health information exchange arising out of or in connection with the provision of or failure to provide health care services. In any civil action for professional negligence or in any proceeding related to such a civil action or in any arbitration, proof of a health care practitioner's, a health care facility's or a patient's participation or nonparticipation in a state-designated statewide health information exchange is inadmissible as evidence of liability or nonliability arising out of or in connection with the provision of or failure to provide health care services. This paragraph does not prohibit recovery or the admission of evidence of reliance on information in a state-designated statewide electronic health information exchange when there was participation by both the patient and the patient's health care practitioner. [PL 2011, c. 691, Pt. A, §20 (RPR).]

C. A state-designated statewide health information exchange to which health care information is disclosed under this section shall provide an individual protection mechanism by which an individual may opt out from participation to prohibit the state-designated statewide health information exchange from disclosing the individual's health care information to a health care practitioner or health care facility. [PL 2011, c. 691, Pt. A, §20 (RPR).]

D. At point of initial contact, a health care practitioner, health care facility or other entity participating in a state-designated statewide health information exchange shall provide to each patient, on a separate form, at minimum:

(1) Information about the state-designated statewide health information exchange, including a description of benefits and risks of participation in the state-designated statewide health information exchange;

(2) A description of how and where to obtain more information about or contact the state-designated statewide health information exchange;

(3) An opportunity for the patient to decline participation in the state-designated statewide health information exchange; and

(4) A declaration that a health care practitioner, health care facility or other entity may not deny a patient health care treatment based solely on the provider's or patient's decision not to participate in a state-designated statewide health information exchange.

The state-designated statewide health information exchange shall develop the form for use under this paragraph, with input from consumers and providers. The form must be approved by the office of the state coordinator for health information technology within the Governor's office of health policy and finance. [PL 2011, c. 691, Pt. A, §20 (RPR).]

E. A health care practitioner, health care facility or other entity participating in a state-designated statewide health information exchange shall communicate to the exchange the decision of each patient who has declined participation and shall do so within a reasonable time frame, but not more than 2 business days following the receipt of a signed form, as described in paragraph D, from the patient, or shall establish a mechanism by which the patient may decline participation in the state-designated statewide health information exchange at no cost to the patient. [PL 2011, c. 691, Pt. A, §20 (RPR).]

F. A state-designated statewide health information exchange shall process the request of a patient who has decided not to participate in the state-designated statewide health information exchange within 2 business days of receiving the patient's decision to decline, unless additional time is needed to verify the identity of the patient. A signed authorization from the patient is required before a patient is newly entered or reentered into the system if the patient chooses to begin participation at a later date.

Except as otherwise required by applicable law, regulation or rule or state or federal contract, or when the state-designated statewide health information exchange is acting as the agent of a health care practitioner, health care facility or other entity, the state-designated statewide health information exchange shall remove health information of individuals who have declined participation in the exchange. In no event may health information retained in the state-designated statewide health information exchange as set forth in this paragraph be made available to health care practitioners, health care facilities or other entities except as otherwise required by applicable law, regulation or rule or state or federal contract, or when the health care practitioner, health care facility or other entity is the originator of the information. [PL 2011, c. 691, Pt. A, §20 (RPR).]

G. A state-designated statewide health information exchange shall establish a secure website accessible to patients. This website must:

(1) Permit a patient to request a report of who has accessed that patient's records and when the access occurred. This report must be delivered to the patient within 2 business days upon verification of the patient's identity by the state-designated statewide health information exchange;

(2) Provide a mechanism for a patient to decline participation in the state-designated statewide health information exchange; and

(3) Provide a mechanism for the patient to consent to participation in the state-designated statewide health information exchange if the patient had previously declined participation. [PL 2011, c. 691, Pt. A, §20 (RPR).]

H. A state-designated statewide health information exchange shall establish for patients an alternate procedure to that provided for in paragraph F that does not require Internet access. A health care practitioner, health care facility or other entity participating in the state-designated statewide health information exchange shall provide information about this alternate procedure to

all patients. The information must be included on the form identified in paragraph D. [PL 2011, c. 691, Pt. A, §20 (RPR).]

I. A state-designated statewide health information exchange shall maintain records regarding all disclosures of health care information by and through the state-designated statewide health information exchange, including the requesting party and the dates and times of the requests and disclosures. [PL 2011, c. 691, Pt. A, §20 (RPR).]

J. A state-designated statewide health information exchange may not charge a patient or an authorized representative of a patient any fee for access or communication as provided in this subsection. [PL 2011, c. 691, Pt. A, §20 (RPR).]

K. Notwithstanding any provision of this subsection to the contrary, a health care practitioner, health care facility or other entity shall provide the form and communication required by paragraphs D and F to all existing patients following the effective date of this subsection. [PL 2011, c. 691, Pt. A, §20 (RPR).]

L. A state-designated statewide health information exchange shall meet or exceed all applicable federal laws and regulations pertaining to privacy, security and breach notification regarding personally identifiable protected health information, as defined in 45 Code of Federal Regulations, Part 160. If a breach occurs, the state-designated statewide health information exchange shall arrange with its participants for notification of each individual whose protected health information has been, or is reasonably believed by the exchange to have been, breached. For purposes of this paragraph, "breach" has the same meaning as in 45 Code of Federal Regulations, Part 164, as amended. [PL 2011, c. 691, Pt. A, §20 (RPR).]

M. The state-designated statewide health information exchange shall develop a quality management plan, including auditing mechanisms, in consultation with the office of the state coordinator for health information technology within the department, who shall review the plan and results. [PL 2011, c. 691, Pt. A, §20 (RPR).]

[PL 2011, c. 691, Pt. A, §20 (RPR).]

20. Exemption from freedom of access laws. Except as provided in this section, the names and other identifying information of individuals in a state-designated statewide health information exchange are confidential and are exempt from the provisions of Title 1, chapter 13.

[PL 2011, c. 373, §4 (NEW).]

SECTION HISTORY

RR 1997, c. 2, §44 (COR). PL 1997, c. 793, §A8 (NEW). PL 1997, c. 793, §A10 (AFF). PL 1999, c. 3, §§1,2 (AMD). PL 1999, c. 3, §§3,5 (AFF). PL 1999, c. 512, §A5 (AMD). PL 1999, c. 512, §A6, 7 (AFF). PL 1999, c. 790, §§A58,60 (AFF). RR 2001, c. 1, §26 (COR). PL 2001, c. 346, §1 (AMD). PL 2009, c. 211, Pt. B, §17 (AMD). PL 2009, c. 292, §3 (AMD). PL 2009, c. 292, §6 (AFF). PL 2009, c. 387, §§1, 2 (AMD). PL 2011, c. 347, §§6-8 (AMD). PL 2011, c. 373, §§1-4 (AMD). PL 2011, c. 572, §1 (AMD). PL 2011, c. 691, Pt. A, §20 (AMD). PL 2013, c. 289, §§1, 2 (AMD). PL 2013, c. 326, §1 (AMD). PL 2013, c. 528, §1 (AMD). PL 2013, c. 528, §12 (AFF). RR 2015, c. 1, §17 (COR). PL 2015, c. 218, §1 (AMD). PL 2015, c. 370, §§4, 5 (AMD). PL 2017, c. 203, §§2-4 (AMD). PL 2017, c. 402, Pt. C, §44 (AMD). PL 2017, c. 402, Pt. F, §1 (AFF). PL 2017, c. 407, Pt. A, §72 (AMD). PL 2019, c. 417, Pt. B, §14 (AFF). PL 2021, c. 398, Pt. MMMM, §§3-5 (AMD).