

117TH CONGRESS <i>1st Session</i>	HOUSE OF REPRESENTATIVES	REPORT 117-
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WORKPLACE VIOLENCE PREVENTION FOR HEALTH CARE
AND SOCIAL SERVICE WORKERS ACT

MARCH --, 2021.—Ordered to be printed

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

R E P O R T

together with

VIEWS

[To accompany H.R. 1195]

[Including cost estimate of the Congressional Budget Office]

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.

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:

Sec. 1. Short title.
Sec. 2. Table of contents.

TITLE I—WORKPLACE VIOLENCE PREVENTION STANDARD

Sec. 101. Workplace violence prevention standard.
Sec. 102. Scope and application.
Sec. 103. Requirements for workplace violence prevention standard.
Sec. 104. Rules of construction.
Sec. 105. Other definitions.

TITLE II—AMENDMENTS TO THE SOCIAL SECURITY ACT

Sec. 201. Application of the workplace violence prevention standard to certain facilities receiving Medicare funds.

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.

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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

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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 prevention 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

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.

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; Patricia 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.

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>.

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 yeas 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/osh3148.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.

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

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>.

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.

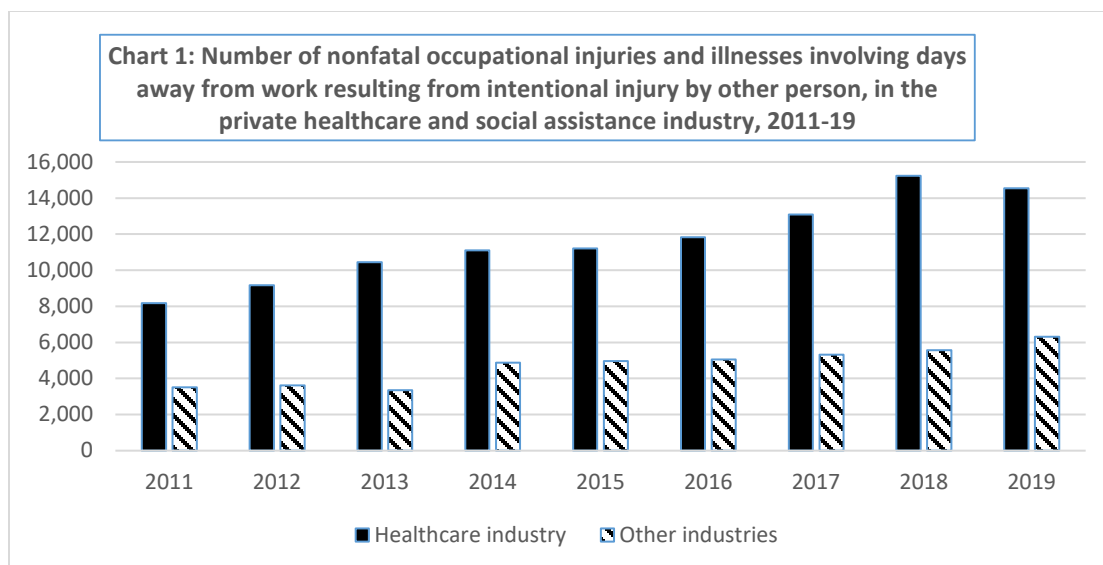
Health Care and Social Service Workers Are Paying the Price of Inaction

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

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>.

in on stretchers. Cleveland Clinic officials say they confiscate thousands of weapons like knives, pepper spray and guns each year. 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.

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).

So, it's just working in those environments there's more opportunity or more tendency for 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 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

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).

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.

In 24 states, nearly 8 million workers employed by state and local governments¹⁹ 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 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

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.

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).

emergency department nurses, the reporting rate is 35 percent²⁴ 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 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

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.

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>.

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 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

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).

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.

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 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

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.

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:

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

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>.

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.americannursestoday.com/code-green-prevents-workplace-violence/>.

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 employer 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:

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).

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/osh3148.pdf>.

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 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

⁴⁷ 29 U.S.C. § 654(a)(1).

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.

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 Administration 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 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

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.

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).

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 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

⁵⁶ Exec. Order No. 13,787, 83 Fed. Reg. 9339 (Jan. 30, 2017).

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>.

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.

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

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).

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).

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:

- **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.

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>.

- **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 2017⁶⁴ 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 2016⁶⁵ 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 standard⁶⁶ 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 standard⁶⁷ 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

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).

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.

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.

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).

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 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

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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: CSUE1X2110233O700
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

Download:  [.xlsx](#)

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: CSUE1X3110133O700
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

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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

Download:  [xlsx](#)

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: CSUE1X3110103O700
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

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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

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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

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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

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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, surveillance 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 patient 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:

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		<i>Vacancy</i>			
Mr. POCAN (WI)		X		<i>Vacancy</i>			
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.

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. COURTNEY (CT)	X			Mr. THOMPSON (PA)		X	
Mr. SABLON (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			<i>Vacancy</i>			
Mr. POCAN (WI)	X			<i>Vacancy</i>			
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 Congressional 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 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, 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 services 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 im-

provement 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 non-participating 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 care (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 provi-

sion 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), sec-

tion 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 administra-

tion 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 un-

less the Secretary finds that the reason for the termination or non-renewal 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 expedited 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 nursing 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 suspension 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 subparagraph (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.

* * * * *

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.
Chairman

The Honorable Bobby Scott

March 26, 2021

Page 2

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

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COMMITTEE ON
EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

March 26, 2021

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VACANCY

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,

A handwritten signature in blue ink, appearing to read "B. Scott".

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.

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

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).

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 Health 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 proposed 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

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.).

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).

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 legislation⁷ 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 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

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).

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.

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 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

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).

¹⁴ Rath statement, *supra* note 8, at 26.

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.

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-

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.

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] assess 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 proceeding. 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

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.

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 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

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.

²⁷ Exec. Order No. 13,999, 86 Fed. Reg. 7211 (Jan. 26, 2021).

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 mandate 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

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>.

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.



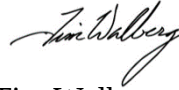
Virginia Foxx
Ranking Member



Joe Wilson
Member of Congress



Glenn "GT" Thompson
Member of Congress

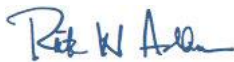


Tim Walberg
Member of Congress



Glenn Grothman
Member of Congress

Elise M. Stefanik
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Rick W. Allen
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Jim Banks
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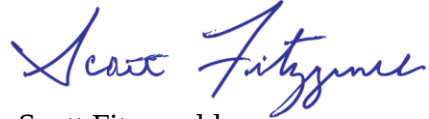


Lisa C. McClain
Member of Congress



Diana Harshbarger
Member of Congress

Mary E. Miller
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Scott Fitzgerald
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Victoria Spartz
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