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Via e-filing on www.regulations.gov

OSHA Docket Office
Docket No. 2016-0014 or RIN 1218-AD 08
Technical Data Center, Room N-3653
OSHA -U.S. Department of Labor
200 Constitution Ave. NW.
Washington, DC 20210

RE: Prevention of Workplace Violence in Healthcare and Social Assistance

Dear Docket Clerk:

On December 7, 2016 the US Department of Labor's Occupational Safety and Health Administration (OSHA) published a request for information (RFI) related to information and data to support commencing with rulemaking proceedings on a standard aimed at preventing workplace violence in healthcare and social assistance perpetrated by patients or clients, including emergency medical care personnel.

The National Association of State Emergency Medical Services Officials (NASEMSO) is a nationwide network of coordinated state, regional and local EMS and emergency care systems, comprised of 50 state and 6 territorial offices/bureaus of emergency medical services (EMS), acting as a strong national voice for EMS professionals. We are an acknowledged key resource for EMS information, as well as a leader in developing and disseminating evidence-based decisions and policies.

NASEMSO deeply appreciates the Agency's efforts to enhance EMS worker safety and encourages OSHA to consider the following facts:

- The occupational fatality rate among Emergency Medical Services workers is 12.7 per 100,000 workers per year, more than twice the national average for all occupations and comparable to rates for police and firefighters.
- The rate of non-fatal injuries among EMTs and paramedics is estimated to be 34.6 per 100 full-time workers per year, a rate more than five times higher than the national average for all workers.
- According to Maguire et al, the risk of non-fatal assault resulting in lost work time among EMS workers is 0.6 cases per 100 workers a year; the national average is about 1.8 per 10,000 workers. The relative risk of non-fatal assault for EMS workers is roughly 30 times higher than the national average. Over a five-year period during which 91 line-of-duty fatalities were identified, 10 (9%) were violence-related. The

relative risk of fatal assaults for EMS workers is about three times higher than the national average.

NASEMSO offers the following selected responses to the RFI as it relates to the EMS workforce:

Section II: Background

Several states, such as Pennsylvania, have enacted legislation to categorize violence towards emergency medical workers in a way that does not protect workers—the legislation simply enables criminal prosecution of perpetrators. NASEMSO is not aware of state legislation that either requires emergency medical workers to report assaults and/or any that provides a mandate for employers to provide prevention training or equipment to protect its workers. In fact, the majority of state statutes to "protect" emergency workers are amendments to criminal codes that categorize assaults on emergency medical professionals as a misdemeanor and many provide exemptions to assaults by patients impaired by medications or to health care workers in private residences.

Section III. Defining Workplace Violence

NASEMSO does not agree with OSHA's assertion that Type I, or criminal intent, perpetrated by criminals with no connection to the workplace other than to commit a crime typically does not apply to healthcare. The media reports frequently on ambulances being stolen for various nefarious purposes from community locations including hospitals primarily for access to controlled substances and in fact, the Department of Homeland Security and the Federal Bureau of Investigation have issued warnings to EMS agencies in the United States about the use of stolen, cloned, or repurposed commercial or official vehicles actively being used in terrorist attacks on foreign soil.

Question III. 1. CDC/NIOSH defines workplace violence as ``violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty'' (CDC/NIOSH, 2002). Is this the most appropriate definition for OSHA to use if the Agency proceeds with a regulation?

NASEMSO acknowledges that OSHA "has no intention of including violence that is solely verbal in a potential regulation." We would encourage OSHA to reconsider this position in regards to the National Institute of Occupational Safety and Health (NIOSH) definition of workplace violence, which includes expressions of intent to cause harm, including verbal threats, threatening body language, and written threats. These actions are often precursors to physical harm and de-escalation training can be an effective means to prevent physical injury.

Question III. 2. Do employers encourage reporting and evaluation of verbal threats? If so, are verbal threats reported and evaluated? If evaluated, how do employers currently evaluate verbal threats (i.e., who conducts the evaluation, how long does such an evaluation take, what criteria are used to evaluate verbal threats, are such investigations/evaluations effective)?

Anecdotal reports from the EMS community indicates that reporting any incidence of workplace violence to local law enforcement for investigation and/or prosecution may be discouraged by an agency/employer that perceives a report to law enforcement as a potential for adverse publicity or litigation. Peer support is also generally lacking and victims are judged on their abilities to "handle the situation." Because of this prevailing attitude, many EMS workers experience apathy towards reporting incidents and accept violence towards them as an expected outcome.

Question III. 3. Though OSHA has no intention of including violence that is solely verbal in a potential regulation, what approach might the Agency take regarding those threats, which may include verbal, threatening body language, and written, that could reasonably be expected to result in violent acts?

NASEMSO suggests that OSHA could require employers to engage in ongoing risk assessment practices, worksite analysis and hazard identification including the identification of controls to eliminate or reduce hazards, and provide training to workers on safety, situational awareness, and de-escalation techniques.

Question III.5. Currently, a mental illness sustained as a result of an assault in the workplace, e.g., Posttraumatic Stress Disorder (PTSD), is not required to be recorded on the OSHA 300 Log ``unless the employee voluntarily provides the employer with an opinion from a physician or other licensed healthcare professional with appropriate training and experience (psychiatrist, psychologist, psychiatric nurse practitioner, etc.) stating that the employee has a mental illness that is work-related (1904.5(b)(2)(ix)).'' Although protecting the confidentiality of the victim is important, an unintended consequence of omitting these incidents from the 300 Log is that the extent of the problem is likely underestimated. In a workplace violence prevention standard, should this exclusion be maintained or be removed? Is there a way to capture the information about cases, while still protecting confidentiality?

NASEMSO asserts that the incidence of critical stress is prevalent in the EMS profession however it will be difficult, if not impossible, for OSHA to quantify the rate of PTSD as it relates to workplace violence because the cause for PTSD in EMS workers is multifactorial (including returning service members now employed in the civilian EMS sector.) In the general population, the National Comorbidity Survey Replication (NCS-R), conducted between February 2001 and April 2003, comprised interviews of a nationally representative sample of 9,282 Americans aged 18 years and older. PTSD was assessed among 5,692 participants, using DSM-IV criteria. The NCS-R estimated the lifetime prevalence of PTSD among adult Americans to be 6.8%. Current past year PTSD prevalence was estimated at 3.5%. The lifetime prevalence of PTSD among men was 3.6% and among women was 9.7%. The twelve-month prevalence was 1.8% among men and 5.2% among women. Rates are significantly higher in military/veterans. Therefore, we believe that the measurement of PTSD is not a useful measure to be recorded on the OSHA 300 Log for the purpose of evaluating the effects of workplace violence and could potentially create a burden to employers.

Rather, we suggest that a workplace violence prevention requirement could help bring awareness to the high rates of critical stress in first responders and encourage practices to reduce the stigma associated with seeking help.

Question III.7: Are there other indicators of the extent and severity of workplace violence in healthcare or social assistance that OSHA has not captured here?

Atypical response profile to other healthcare workers: EMS personnel are involved in a range of healthcare activities, such as 9-1-1 response for illness and injury, medical "stand-by" at special events, large concerts and sporting venues where alcohol is served, or an unplanned response for large-scale natural (and manmade) disasters. In addition to potential risk involving these situations, violence-prone response to domestic violence, active shooter scenarios, and other terrorist related events, where victims/patients may need to be extricated from life-threatening situations, are happening with increasing frequency. In these circumstances, workplace violence isn't always committed by patients or clients but by other aggressors and OSHA should be careful not to inadvertently limit the effect of proposed rules by naming patients and/or clients alone as the perpetrators of violence against workers.

Rate of Suicide: An informal study conducted by an EMS management group in 2015 resulted in 4,022 voluntary responses. The results showed that 3,447 (86%) of the 4,022 respondents experienced critical stress, 1,383 (37%) of the respondents had contemplated suicide, and 225 (6.6%) had actually tried to take their own life. Unless ALL suicides by EMS workers are required to be reported, the data will fail to capture the true magnitude of this issue because the majority of EMS suicides occur during off-duty periods and an employer may not associate or report the incident to the 300 Log as a fatality.

Mitigating effects of mental health and cognitive impairment of patients:
Substance abuse among the US population including the widespread opioid epidemic is a well-documented fact. Opioids act as a central nervous depressant, causing decreased level of consciousness and respiratory depression. Naloxone, a common medication carried by most Advanced Life Support (i.e. paramedic) services for decades, reverses its effects by blocking opioid receptors. Approximately 80% of states now authorize the use of naloxone at the basic life support level. In 2004, Belz and colleagues reported a retrospective case series review of patients treated by EMS responders. A total of 164 patients aged 14–86 years were treated with naloxone by IV (primarily), IM, or IN routes that illustrated naloxone associated violence in 15% of cases. Since that time, the incidence of opioid overdose treated with naloxone has increased exponentially although the association of related violence to EMS workers has not been studied.

More recently (March 16, 2017), one member of New York City's emergency medical services was killed and another critically injured when a man hijacked an their ambulance and ran over one of them. According to various media reports, relatives of the man who was taken into custody said he had been depressed since his mother died when he was an adolescent. The man was known to the police because they have had numerous encounters with him as an emotionally disturbed person.

Aggressive and violent behavior also poses severe problems in caring with people with metabolic issues (such as low blood sugar), autism spectrum disorder, attention deficit hyperactivity disorder, bipolar disorder, schizophrenia, PTSD, traumatic brain injury, stroke, certain infections and illnesses and dementia are potentially encountered by EMS personnel on a daily basis. Because of the complex nature of these disorders and the ethics and sensitivity in criminally charging patients for violent actions due to medical conditions, data in this regard is not widely available even though health care workers including EMS still need to be protected from resulting injuries.

Security of equipment and personnel:
As previously mentioned, the Department of Homeland Security and the Federal Bureau of Investigation have issued warnings to EMS agencies in the United States about the use of stolen, cloned, or repurposed commercial or official vehicles actively being used in terrorist attacks on foreign soil.

It is noted that in the 4 months that OSHA has collected information via this notice, criminal activity related to impaired individuals targeting ambulances for a variety of purposes including access to pharmaceuticals has been reported 11 times by the media. On December 3, 2016, an ambulance was stolen from a trauma center entrance in Austin, TX following a patient transfer. On December 25, 2016 another ambulance was hijacked in Austin, TX near a homeless center while paramedics in the back were treating a patient. On January 9, 2017 an ambulance was stolen in Los Angeles, CA while medics were inside a home. On January 25, 2017 an ambulance was stolen in Corpus Christi, TX while paramedics were treating a patient inside their home. On January 30, 2017, a person stole an ambulance in Sydney, OH from an ER entrance while paramedics were trying to restock supplies. On February 27, 2017, an ambulance has hijacked while paramedics were treating a patient in the back in Youngstown, OH. On March 11, 2017, a man stole an ambulance from an Alabama hospital entrance, leading police on a high-speed chance. On March 16, 2017, an EMT was killed and another critically injured in the Bronx during an ambulance hijacking. On March 22, 2017, an elderly patient upset with the quality of care he was receiving in East Meadow, NY stole an ambulance from the hospital parking lot. On March 31, 2017, yet another ambulance was stolen from the South Austin (TX) Medical Center patient drop off location. On April 4, 2017, an ambulance was stolen from an ER entrance in Palestine, TX, leading police on a high-speed chase. NASEMSO acknowledges that basic security measures could have prevented some of these incidents but the risk of confronting persons with the intention of committing a crime could lead to workplace violence and should be considered.

Section IV. Scope

Question IV.1. How would you suggest OSHA approach the issue of whom should be included in a possible standard?

The Bureau of Labor Statistics Standard Occupational Classification (SOC) system could be utilized for this purpose, specifically, Group 21-0000 Community and Social Service Occupations, Group 29-0000 Healthcare Practitioners and Technical Occupations, 31-0000 Health Support Occupations, and 43-0000 Office and Administrative Support Occupations.

Section V. Workplace Violence Prevention Programs; Risk Factors and Controls/Interventions

Question V.3: In your experience, what are the important factors to consider when implementing a workplace violence prevention program or policy?

We believe that a multidisciplinary approach that includes EMS management, EMS workers, consumer representatives, community leaders, and law enforcement is the most effective means to identify risk factors, controls, and interventions that could be used to advise a workplace violence prevention program or policy in EMS, especially in high risk neighborhoods.

Section VI. Costs, Economic Impacts, and Benefits

Question VI.1: Are there additional data (other than workers' compensation data) from published or unpublished sources that describe or inform about the incidence or prevalence of workplace violence in healthcare occupations or settings?

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States. ICD-10 is used for all general epidemiological, public health surveillance, reimbursement, and many health management purposes. Special codes are utilized to document patient status at the time of injury. OSHA economists might find this information useful when evaluating external causes and the utility and cost in employees hospitalized by workplace violence.

In summary, NASEMSO shares OSHA's belief that management commitment and worker participation are essential elements of an effective violence prevention program. We support federal efforts to reduce preventable injury, illness, and death among emergency responders and encourage OSHA to proceed with rulemaking in regards to workplace violence in healthcare and social assistance sectors. Should OSHA proceed with the rulemaking process, NASEMSO would be honored to help serve the agency in this manner.

Please feel free to contact NASEMSO Program Manager, Kathy Robinson, RN (robinson@nasemso.org) or (703) 538-1799 extension 1894 for additional information.

Sincerely,

Keith Wages
President
National Association of State EMS Officials

RESOURCES:

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