Addressing Workplace Violence in Healthcare Through Occupational Safety and Health

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University Disclaimer

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

Client Disclaimer

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Honor Pledge

On my honor as a student, I have not given nor received unauthorized aid on this assignment.

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Acronyms

CSHO: Compliance Safety and Health Officer

DAFW: Days Away From Work

DART: Days Away, Restricted, Transferred

DCSP: Directorate of Cooperative and State Programs (in OSHA)

DSG: Directorate of Standards and Guidance (in OSHA)

NAICS: North American Industry Classification System

OSHA: Occupational Safety and Health Administration

OSP: Office of State Programs

PIRFA: Potential Initial Regulatory Impact Flexibility Analysis

WPV: Workplace Violence

WVPP: Workplace Violence Prevention Plan

Definitions

Healthcare facility: All workplaces that provide healthcare to individuals, such as hospitals, clinics, ambulatory services, and residential care facilities (BLS, n.d.).

Healthcare worker: Any occupation providing medical care or assistance, such as nurses, physicians, and psychiatrists. (BLS, n.d.).

Standards: Rules published by OSHA (and State Plans) containing requirements for ensuring worker safety within a workplace that employers need to comply with (OSHA, n.d.).

State Plans: OSHA approved state legislature for states to carry out separate occupational safety and health plans. They are monitored and evaluated by OSHA and required to adopt all standards and National Emphasis Programs of OSHA (OSHA, 2020).

Workplace violence: An act or a threat of physical violence or verbal harassment experienced in the workplace, ranging from verbal abuse to physical assaults to homicide (OSHA, 2015; NSC, 2023).

Executive Summary

The Occupational Safety and Health Administration (OSHA) in the United States Department of Labor is responsible for ensuring employers provide workers with safe and healthy work environments (OSHA, n.d.). A growing issue impacting worker safety and health is workplace violence (WPV). The rate at which workers experience WPV has almost doubled since 2010 (NSC, 2023). Furthermore, the estimated nearly 14 million healthcare workers covered by OSHA experience injury from WPV at a rate almost five times higher than the average for all industries (BLS, 2024; OSHA, 2023).

In healthcare, workers experience violence most often from patients (OSHA, 2015; Pitts &Schaller, 2023). This causes both physical injury and mental harm to healthcare staff, who consequently experience dissatisfaction in their work. The impact on healthcare workers leads to decreased quality of patient care. Furthermore, it also leads to higher costs to healthcare facilities as the issue increases worker turnover rates and injury compensation claim rates (Caruso et al., 2022; Lactot & Guay, 2014; O'Brien et al., 2024).

Surveys reveal only 62.8% of healthcare employers provide WPV prevention training for healthcare staff, and only around 30% have a system of reporting and recording cases of patient violence (NNU, 2024). This is compounded by an already existing culture of underreporting, as many healthcare workers assume violence is "part of the job" (Arnetz et al., 2015).

Given the information, the problem OSHA is facing is:

An estimated 58% of healthcare workers experience WPV, with a majority of cases being physical and verbal assaults from patients in hospitals (Sahebi et al., 2022). In the United States, there is a lack of federal regulations and initiatives to ensure that healthcare employers effectively implement worker protections, resulting in harm to healthcare staff, decreased quality of patient care, and increased costs for healthcare facilities (OSHA, 2015; NNU, 2024).

Solutions to address this growing issue draw on effective measures for both the healthcare industry and OSHA. Solutions are evaluated by effectiveness at reducing worker experience of

injury from WPV, cost to OSHA and healthcare facilities, and feasibility to implement. Three policy alternatives OSHA can implement to address this issue are:

1. Status Quo – A New Standard
2. Increasing Inspections
3. Training and Strategic Partnerships.

Alternative 1 suggests that OSHA continue implementing the Workplace Violence in Healthcare and Social Assistance Standard, which has been in progress since 2016 (OIRA,2025). This standard would require healthcare employers to adopt workplace violence prevention plans that include comprehensive measures to protect staff (OSHA, 2023). Drawing on literature estimating the effectiveness of OSHA's standards and inspections, as well as WVPP in healthcare, this alternative may reduce healthcare workers' experience of WPV by 12.59 per 10,000 workers (Haviland et al., 2012; Henderson et al., 2014; Escue, 2013; Gray & Scholz, 1993; Levine et al., 2012; Okundolor, 2013). This measure is estimated to cost $658,953.05 to OSHA and $7,399.61 per healthcare facility to implement. Regarding feasibility, this alternative ranks medium. Increasing regulations may not be favorable to the new administration or healthcare facility employers (Dumain, 2024; Ferguson, 2025). However, healthcare workers and their associations have advocated for increased regulations regarding this issue and support the measure (MHA, 2023; NNU, 2024).

Alternative 2 would require OSHA to direct all Compliance Safety and Health Officers (CSHOs) to increase inspections in the healthcare industry by 5%. Using literature that assesses the impact of OSHA enforcement on the reduction of worker injury across industries, this alternative has an estimated effectiveness of reducing injury from WPV by 9.3 per 10,000 workers (Haviland et al., 2012; Gray & Scholz, 1993; Levine et al., 2012). This alternative is expected to cost OSHA $14,088,220.34, and per healthcare facility $2,575.79. This alternative ranks low on feasibility. There are only enough CSHOs to inspect every workplace once every 145 years, therefore efforts to redirect their time are not widely supported (Committee on Education and Workforce, 2022; AFL-CIO, 2024; Michaels, 2018).

Alternative 3 combines two OSHA programs to create free online WPV prevention training for all healthcare employees, supported and promoted by strategic industry partners such as unions

and associations. Literature suggests that the effectiveness of this alternative would result in a reduction of injuries from WPV at a rate of 11.95 per 10,000 workers (Gillam et al., 2014; Irvine et al., 2012). It is important to note that training uptake is estimated at 62.8% (NNU, 2024). This alternative would cost $1,202,902.74 for OSHA and $12,293.47 per healthcare facility. This alternative ranks high in feasibility as it is an optional program, and the two base programs typically have widespread support (Dumain, 2024; Michaels, 2018; OSHA, 2024).

Taking into account the assessment of each alternative, OSHA should pursue Alternative 1: Status Quo – A New Standard. This alternative creates permanent change in healthcare and holds employers accountable for the safety of healthcare workers.

Introduction

The mission of the Occupational Safety and Health Administration (OSHA) in the United States Department of Labor (DOL) is to ensure that employers provide workers with a safe and healthy workplace (OSHA, n.d.). A growing issue endangering workers today is workplace violence (WPV), most prominently impacting workers in the healthcare industry who experience violence from patients (BLS, 2024; OSHA, 2015). This issue has severe consequences for healthcare workers, patients, and healthcare facility employers (O'Brien et al., 2024; Lactot & Guay, 2014). A lack of regulations requiring employers to have preventative measures in place compounds patient outbursts of violence, worsening the issue (Caruso et al., 2022; Fairfax, 2020). Literature reveals comprehensive workplace violence prevention programs (WVPP), as well as OSHA enforcement mechanisms such as standards and inspections, can be effective at reducing worker injuries from WPV (Haviland et al., 2012; Henderson et al., 2014; Escue, 2013; Gray & Scholz, 1993; Levine et al., 2012; Okundolor, 2013). OSHA can intervene by publishing a standard that mandates all healthcare facilities to implement comprehensive prevention programs, increasing inspections of healthcare facilities, or creating free online training supported by strategic industry partners. Taking into account effectiveness, cost, feasibility, and implementation, the overall recommendation is for OSHA to publish a standard requiring all healthcare facilities to implement comprehensive prevention programs.

Problem Statement

An estimated 58% of healthcare workers experience workplace violence (WPV), with a majority of cases being physical and verbal assaults from patients in hospitals (Sahebi et al., 2022). In the United States, there is a lack of federal regulations and initiatives to ensure that healthcare employers effectively implement worker protections, resulting in harm to healthcare staff, decreased quality of patient care, and increased costs for healthcare facilities (OSHA, 2015; NNU, 2024).

Client Overview

The client is the Occupational Safety and Health Administration (OSHA) at the United States Department of Labor (DOL). OSHA covers most workplaces across the nation (See Appendix A for coverage specifications). Issues such as workplace violence infringe on a worker's right to

safe and healthy work conditions, which fall under the jurisdiction of OSHA to protect through the Occupational Safety and Health (OSH) Act of 1970. The OSH Act gives OSHA the power to create and enforce workplace safety standards that employers must follow in order to provide safe and healthy working conditions for the over 170 million workers in the United States (BLS, 2025; OSHA, n.d.). OSHA utilizes inspections and penalties to monitor employer compliance and outreach programs to support employer compliance. OSHA has 10 regional offices in the United States with 853 Compliance Safety and Health Officers (CSHOs) who conduct local inspections (OSHA, n.d.; AFL-CIO, 2024).

Workplace Violence

Significant progress has been made in reducing workplace injuries, illnesses, and fatalities since the creation of OSHA in 1970. The number of workplace fatalities per day has decreased by over 50% from 1970 to 2023. Similarly, the rate of workplace injuries has dropped eight percentage points from 1972 to 2023 (OSHA, 2023). Despite these improvements, workplace injuries, illnesses, and fatalities are still unacceptably high. In 2023, 5,283 workers died on the job, and 2.6 million experienced work-related injuries and illnesses, with injuries accounting for 92% of the total. Since 2020, workplace illnesses have declined, but workplace fatalities have increased by 10%, and injuries have remained unchanged at around 2.3 million (AFL-CIO, 2024; BLS, 2023). While OSHA has successfully addressed traditional hazards, such as safety hazards causing trips and falls, it has not yet been as effective in addressing complex issues, such as work organization hazards like workplace violence (Fairfax, 2020; ELI, 2016).

Workplace violence (WPV) is considered any act or threat of physical violence or verbal harassment experienced in the workplace. It includes verbal abuse, physical assaults, and homicide, and is categorized into four types:

- Type I: Violence by criminals with no relationship to the workplace or employees;
- Type II: Violence by customers, patients, or their families;
- Type III: Violence by coworkers or colleagues;
- Type IV: Violence involving personal relationships (ANA, 2021).

Scale

WPV is a serious, growing threat to worker safety. In 2022, 524 people died in their workplace due to WPV, which is an 8.9% increase from 2021 (BLS, 2024). A much more widespread result of WPV is nonfatal injuries. A combined report from the Bureau of Justice Statistics (BJS), the National Institute for Occupational Safety and Health (NIOSH), and the Bureau of Labor Statistics (BLS) found that workers experienced an annual average of 1.3 million incidents of nonfatal WPV from 2015 to 2019 (BLS, BJS & NIOSH, 2022). Furthermore, between 2021 and 2022, OSHA reported 57,610 cases of nonfatal WPV injuries that resulted in a worker taking days away from work to recover, required restricted work as a result, or required transferring jobs - known as days away from work, restricted, or transferred (DART) (BLS, 2024). Shown in Figure 1 below, worker nonfatal injuries resulting in just days away from work to recover (DAWF)[1] due to WPV have steadily increased since 2010 (NSC, 2023).

[1] Severity of threats to worker safety is typically measured through the number or rate of injuries that require workers to take days away from work (DAFW) for recovery, but as of 2021, BLS has begun instead measuring severity using days away from work, job restriction, or transfer (DART) to include for job restriction or transfer (BLS, 2024; NSC 2023).

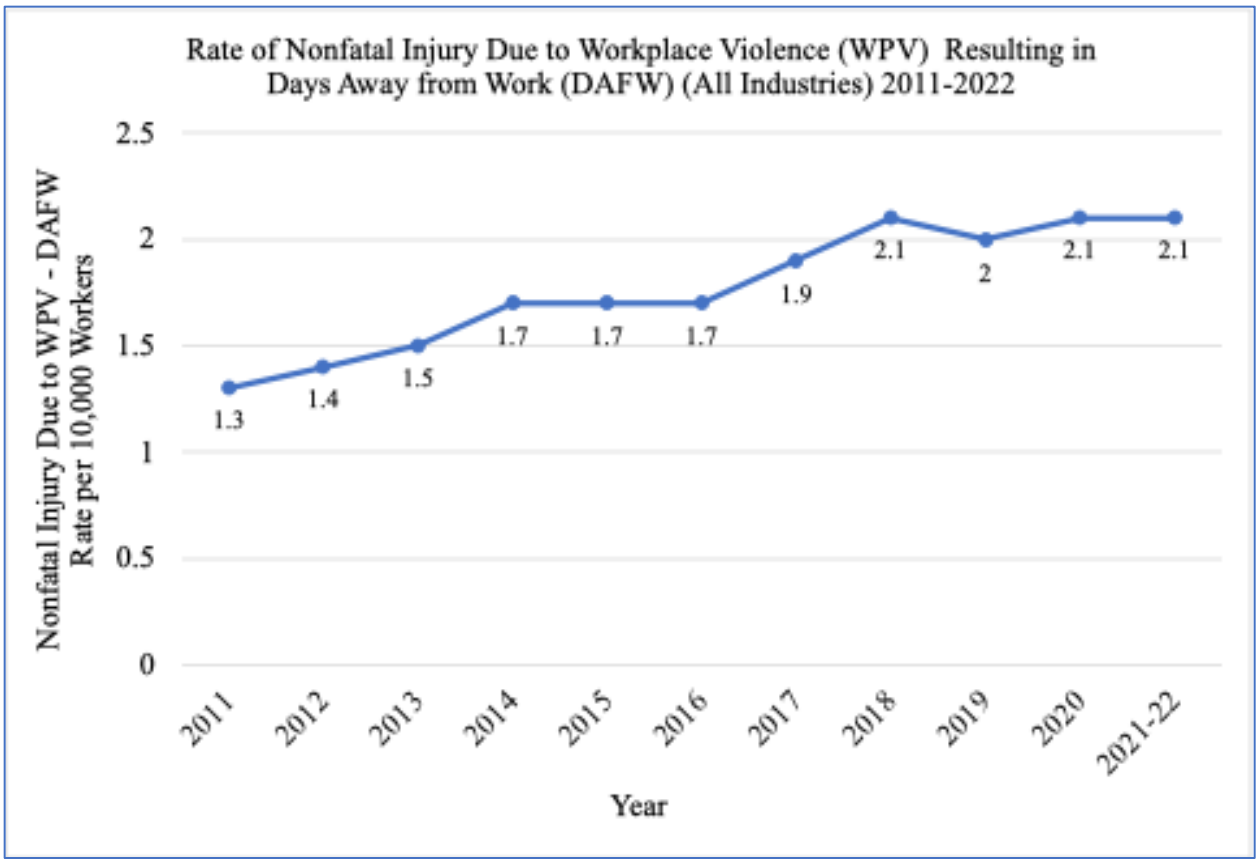

Figure 1 (NSC, 2023)[2]

Scope

The prevalence of WPV is particularly alarming in healthcare. From 2021 to 2022, the healthcare industry accounted for 72.8% of all nonfatal WPV cases resulting in DAFW (BLS, 2024). According to OSHA and BLS classifications, this industry encompasses behavioral health facilities, hospitals, residential care facilities, home healthcare services, social assistance, and emergency medical services (See Appendix C for the industry breakdown according to the North American Industry Classification System (NAICS)) (OSHA, 2023). The annual rate of WPV within healthcare facilities is 14.2 per 10,000 full-time workers, compared to the average rate of 2.9 across all industries, meaning healthcare workers experience violent incidents at a rate five times higher than workers across all industries combined (BLS, 2024). The comparison of industry data is highlighted in Figure 2 below.

[2] National Safety Council (NSC) derived these estimates from BLS. In 2021, BLS began biennial reporting, in 2023 BLS transitioned to a new reporting classification system, therefore WPV injury statistics have not yet been released past 2021-2022 (BLS 2024; NSC, 2023).

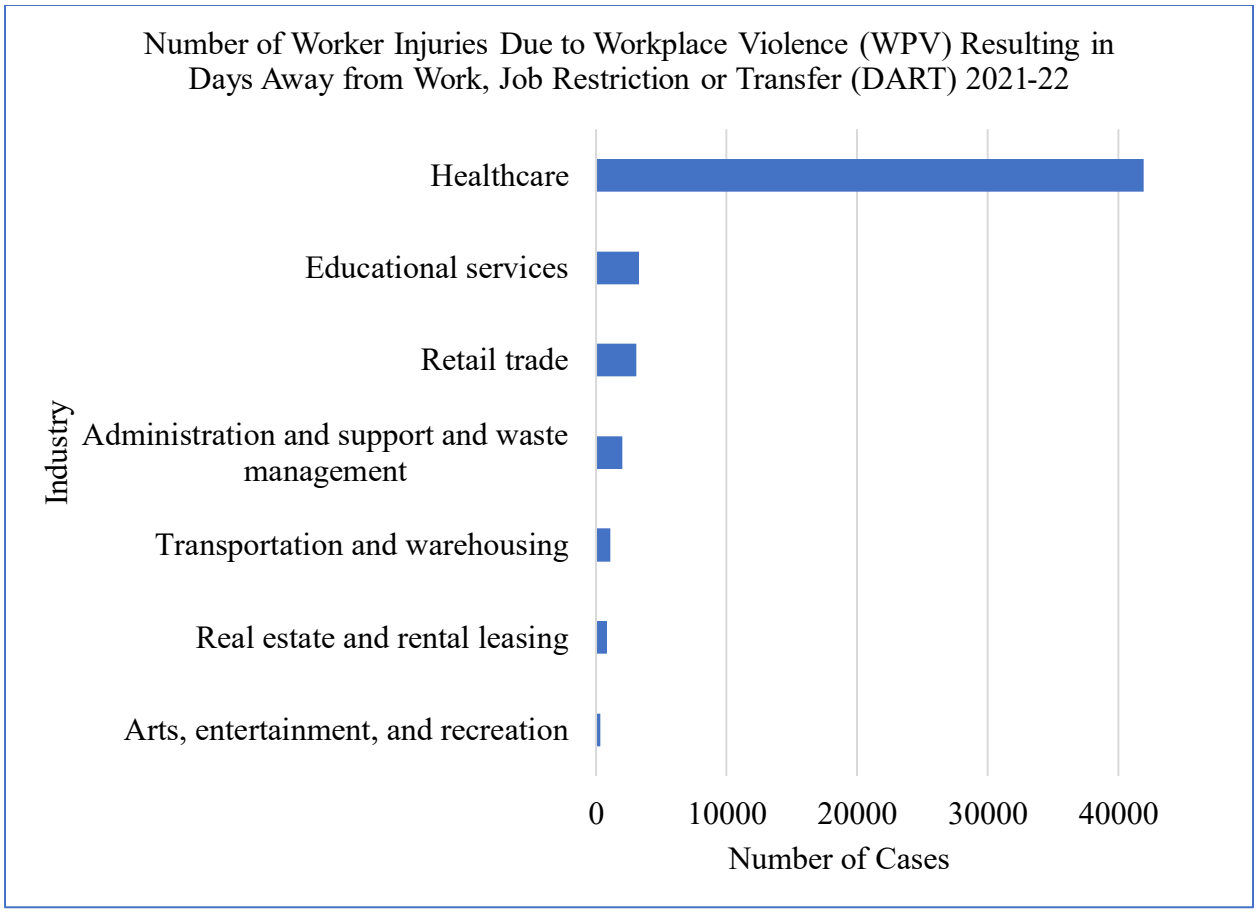

Figure 2 (BLS, 2024)

Populations Involved

OSHA estimates they cover about 14 million healthcare workers, such as physicians and nurses, across 300,447 facilities, such as hospitals and clinics (OSHA, 2023). An estimated 58% of this population experience WPV in their careers (Sahebi et al., 2022). The majority of violent incidents in healthcare involve Type II violence, where patients or their families are the primary aggressors (OSHA, 2015). Violent patients are most often men under the age of 35 (Pitts & Schaller, 2023). These incidents are most frequent in emergency departments within hospitals, psychiatric hospitals, and long-term care facilities. Out of all occupations in this industry, nurses experience the most WPV as they spend the most amount of time having direct contact with patients (Huckenpahler & Gold, 2022).

It is important to note the impact WPV has on women specifically. In 2022, 72.5% of healthcare workers who reported DART injury cases due to WPV were women. This estimate is likely a

result of the fact that women accounted for 78.2% of healthcare workers in 2022 (BLS, 2024). However, more literature is needed to better understand the impact on women (ILO, 2014).

Causes

A culture of under-valuing workplace safety and health compounded by a lack of regulations and resources leads to a lack of preventative measures, perpetuating workplace violence. Many healthcare workers view violence as an unavoidable aspect of their profession, particularly in high-risk fields such as emergency and psychiatric care. This culture discourages reporting, leading to an estimation that as many as 88% of healthcare workers do not report WPV cases, creating inaccurate data and hindering progress toward effective preventative measures (Arnetz et al., 2015; Strickler, 2013; Ma & Thomas, 2023). Furthermore, surveys indicate only 62.8% of healthcare employers provide workplace violence prevention training, and only 30% have methods of reporting violence (NNU, 2024). Literature suggests that a lack of accountability demoralizes employees and normalizes accepting violence (O'Brien et al., 2024). An interview with a threat assessment officer at the University of Virginia Heath revealed that even if a healthcare facility has workplace violence prevention measures in place, many workers are unaware of the resource due to a lack of education and training on the issue. (Personal Communication, 2024).

Inaction from healthcare facility employers also contributes to a workplace environment that does not prioritize preventative measures, such as violence prevention training or even tracking violent incidents. Federal OSHA does not have a standard, safety regulation employers must comply with, on WPV. As a result, healthcare facilities are not required to address WPV, except in the nine State Plans, state-run safety and health programs, with WPV standards (ANA, 2021; MHA, 2023). Additionally, healthcare facilities struggle to implement workplace violence prevention measures due to a lack of time and personnel to conduct effective training or spearhead implementation (Salmon et al., 2021). A 2023 national survey of nurses revealed that only around 30% of healthcare facilities have at least one measure in place to respond to or prevent workplace violence, and nearly 45% of healthcare employers ignore cases of workplace violence (NNU, 2024). These issues contribute to workplace violence being an increasing safety concern for healthcare workers.

Characteristics of patients that lead to workplace violence are exacerbated by the lack of resources to implement preventative measures in both OSHA and the healthcare industry. Healthcare workers are overburdened, and some healthcare facilities are understaffed (O'Brien et al., 2024; Caruso et al., 2022). Furthermore, for healthcare facilities that do or would like to implement workplace violence prevention but need support or guidance, the OSHA CSHOs and Safety and Health Consultants designated to provide support are understaffed (Fairfax, 2020; Michaels, 2018). Additionally, measures to prevent workplace violence are additional costs to healthcare facilities. Training programs can be expensive, hiring security staff to respond to violent incidents is an additional cost, and implementing new processes to prevent violence is time-consuming (Salmon et al., 2021; Caruso et al., 2022). These issues negatively compound on the patient-related factors of violence: experiencing symptoms of mental illness, substance abuse, and severe pain. Lack of resources to provide violence prevention measures, understaffing causing longer wait times, and the stressful environment of healthcare facilities all increase the likelihood of escalations of aggression and confrontations by worsening the patient-related factors of violence (Dal Pai, 2018; Strickler, 2013).

Consequences

Workplace violence in the healthcare industry has significant consequences for workers, patients, and hospitals. These consequences span physical, psychological, and financial impacts (Lanctôt & Guay, 2014).

Cost to Workers

Workplace violence takes a physical and psychological toll on healthcare workers. Over 20% of violent incidents result in physical injuries such as cuts, bruises, and broken bones (O'Brien et al., 2024; BLS, BJS & NIOSH, 2022). Many violent incidents also result in days away from work and job transfer. The psychological impact is just as severe, with many healthcare workers suffering from post-traumatic stress disorder, anxiety, depression, and burnout (Lim et al., 2022; NNU, 2024). Furthermore, many workers feel demoralized and unsafe in their workplaces. A 2023 survey revealed that after experiencing workplace violence, 65% of nurses felt increased anxiety and fear in their workplace, and nearly 30% reported experiencing difficulty continuing to work in the same environment due to trauma (NNU, 2024).

Cost to Patients

The consequences of workplace violence extend beyond workers to impact patient care. When healthcare workers experience violence, the quality of care they can deliver is impaired. Increased prevalence of workplace violence is correlated to a decrease in workers' emotional well-being, making it harder for them to maintain focus and compassion- which are vital to patient care (Caruso et al., 2022; Jones et al., 2023). The emotional and physical toll can reduce a healthcare worker's effectiveness, resulting in the risk of medical errors and delayed responses to patient needs (Gillespie & Tamsukhin, 2023).

Cost to Hospitals

Healthcare facilities also face costs as a result of workplace violence through direct financial costs and operational disruptions. One immediate financial impact is the cost of worker's compensation claims for injuries sustained during violent incidents. Furthermore, workers injured in violent encounters may require extended time off, which can lead to increased hospital costs due to staffing shortages (Lanctôt & Guay, 2014). In 2015, OSHA estimated the average cost of treatment and lost wages for healthcare workers who experience injury as a result of workplace violence to be around $3,000. In addition, some healthcare workers chose to leave the profession due to the trauma of experiencing workplace violence. This decline in staff satisfaction and turnover results in additional costs to healthcare facilities. The estimated cost of replacing a nurse position at a healthcare facility can vary between $27,000 and $103,000 (OSHA, 2015; Jones et al., 2023). Lastly, healthcare facilities face indirect costs as a result of workplace violence, such as increased insurance premiums and potential legal fees if violent incidents lead to lawsuits (O'Brien et al., 2024).

Policy Alternatives

In seeking solutions, the following policy alternatives combine actions from both the healthcare industry and OSHA that literature suggests may effectively reduce worker injury from WPV. In the healthcare industry, workplace violence prevention programs (WVPP) have proven effective at decreasing the occurrence of WPV. These multi-step programs, developed and implemented by healthcare facilities, include comprehensive measures such as establishing violence reporting systems, conducting training sessions, and enhancing safety controls (Gillespie et al., 2014;

Gillespie & Tamsukhin, 2023; Henderson, 2013; Escue et al., 2023; Okundolor et al., 2020). Another alternative explored in this report is training, which, despite having a minimal impact on reducing injuries, is highly effective at boosting worker confidence in dealing with violent incidents (Chang et al., 2022; de la Fuente et al., 2019; Irvine et al., 2012). Concerning OSHA actions to be integrated with these healthcare interventions, literature indicates that enforcement mechanisms are effective. OSHA enforcement involves setting health and safety standards that employers must follow, inspecting workplaces for compliance, and imposing penalties for noncompliance (Foley et al., 2012; Gray & Scholz, 1993; Haviland et al., 2012; Levine et al., 2012). Additionally, OSHA can implement outreach programs, such as creating training initiatives and forming strategic partnerships within industries to enhance compliance; however, there is limited literature on the effectiveness of these programs (Gillam et al., 2014; Irvine et al., 2012; OSHA, 2024)

1. Status Quo – A New Standard

The first policy alternative is for OSHA, specifically the Directorate of Standards and Guidance (DSG), to continue finalizing and publishing the Workplace Violence in Healthcare and Social Assistance standard (OSHA, n.d.). In 2016, OSHA began creating this standard, a process that typically lasts seven to nine years[3] (OIRA, 2025; OSHA, 2012).

If published and enforced, this standard will require all healthcare and social assistance facilities to create and implement a workplace violence prevention program (WVPP). The purpose of this standard is to reduce the injury rate from WPV by holding healthcare employers accountable for the requirements of the standard and giving penalties for noncompliance (See Appendix B for penalty amounts). This standard is similar to informational guidelines OSHA has published regarding WVPP in healthcare, which a panel of safety and health professionals found would be useful if enforced (Berezdivin, 2008).

Specifically, healthcare employers will be required to:

- Write facility-wide policy of a WVPP;

[3] There are no Federal OSHA standards on WPV. There are only nonenforced option guidelines similar to this standard. However, nine State Plans have implemented varying WVP standards (ANA. 2021; OSHA n.d.). None have been studied other than California, which showed increased reporting in the first year of implementation (Doucette et al., 2022).

- Conduct a facility-wide hazard assessment and review of reported violent incidents;
- Put in place environmental safety controls (code call buttons, alarm systems, metal detectors, etc.);
- Train staff that care for or are in contact with patients on de-escalation tactics and violence prevention methods;
- And maintain a record of violent incidents for continuous review (OSHA, 2023).

In the Preliminary Initial Regulatory Impact Flexibility Analysis (PIRFA) from 2023, OSHA estimated that this standard would apply to 23 different healthcare employment classifications, 300,447 facilities, and nearly 14 million workers (See Appendix C for NAICS breakdown) (OSHA, 2023).

A Notice of Proposed Rulemaking with the proposed standard is currently scheduled to be released in June 2025 (OIRA, 2025). There will be another few months of public comments and revisions, and then the standard will be published for enforcement in early 2026. This only occurs if the current presidential administration and newly appointed Labor Secretary Chavez-DeRemer decide to continue with this action (Ferguson, 2025; OSHA, 2012).

2. Increase Inspections in the Healthcare Industry

The second alternative is for OSHA to increase the number of annual inspections conducted at healthcare facilities. OSHA has a National Emphasis Program (NEP) which allows the Directorate of Enforcement Programs (DEP) to publish directives for CHSOs to increase annual inspections in industries with high injury rates (OSHA, n.d.). OSHA can create a directive using the NEP to increase CSHO inspections of healthcare facilities by 5% annually, based on increases in inspections in prior NEPs (OSHA, 2022). In order to do so, there will be a 5% decrease in CSHO inspections in other industries (OSHA, 2023). OSHA conducts about 34,000 inspections per year; healthcare facilities make up 12% of these– this alternative would bring the amount up to 17% (Abyde, 2022).

This alternative attempts to reduce injuries from WPV by increasing inspections in healthcare facilities to ensure industry-specific forms of WPV protections are in place, such as trainings, security alarms, and violent incident reporting systems (Huckenpahler & Gold, 2022). An important distinction to note in this alternative is that it does not change any regulations or

requirements of employers, as it does not create a standard. If, following an inspection, a CSHO believes a facility is not adequately protecting workers from WPV, a penalty can be issued under the General Duty Clause (See Appendix B for penalty amounts) (McCormack, 2022; OSHA, n.d.). The General Duty Clause is within the OSH Act of 1970 and broadly stipulates that all employers need to provide safe and healthy work environments (OSHA, n.d.).

The process of creating and releasing a directive in the NEP will require an estimated seven months, with a goal of public release in late 2025 and enforcement beginning in early 2026 (OSHA, n.d., 2022; Fairfax, 2020).

3. Training and Strategic Partnerships

The third alternative is for OSHA to create and publish a free, optional, and online training course on WPV prevention in the healthcare industry and simultaneously leverage strategic partnership programs to support the development and dissemination of the training to employers and workers. The course will be hosted on OSHA's website. This would require the Directorate of Cooperative and State Programs (DCSP) to create the training course and utilize the Strategic Partnership Program to form partnerships with key unions and associations in the healthcare industry (OSHA, n.d.).

Specifically, partners include the American Hospital Association (AHA), Service Employees International Union (SEIU), and National Nurses United (NNU) (AHA, n.d.; NNU, n.d.; SEIU, n.d.). These partners would provide specialized insights to support the development of the training program. Equally as important, these partners will also utilize their networks to advocate for healthcare employers to uptake the training, given it is an optional program.

The intended goal of this alternative is for the training to be implemented and therefore influence employer and worker handling of WPV to reduce injury rates. This training course would target both employers and employees, and contain:

- the importance of addressing WPV;
- steps to create a suggested WVPP in their own facilities, closely following guidelines from the potential standard discussed in Alternative 1;
- and de-escalation and violence prevention training.

Training for administrative healthcare staff would focus on WVPPs and last one hour, and training for patient care staff would focus on de-escalation training and last three hours. DCSP is a small directorate in OSHA, given the scope of the work, it is estimated to take several months to form the strategic partner and create the training materials, with a goal of publication in early 2026 (OSHA, n.d.).

Criteria

Each policy alternative will be evaluated by the following criteria in order to make effective comparisons that will inform the ultimate recommendation.

1. Effectiveness

Effectiveness is defined as the estimated reduction of healthcare worker injury from WPV. This is measured by the rate of reported incidents per 10,000 workers. The evaluation will be informed by corresponding literature.

2. Cost

This criterion will estimate the monetary cost of each policy alternative to OSHA and healthcare employers. Anticipated costs include current or additional employee wages ranging from administrative to patient care staff and resources such as technology. Costs are derived from estimated labor burden, wages and benefits sourced from BLS (generalized and averaged across the nation), and information on OSHA and hospital resources.

3. Feasibility

Feasibility will measure the extent to which each policy alternative is likely to have sufficient support for implementation. This will include multiple dimensions: the feasibility of OSHA implementing each alternative, the likeliness of employers to take up each alternative, and the estimated stances of unions and the workers they represent. Considerations rely on the political landscape, costs incurred, employee impact, and resources required.

Analysis

Alternative 1. Status Quo – A New Standard

Criteria 1. Effectiveness

There is a minimal amount of literature directly aligned with Alternative 1. Status Quo – A New Standard. As a result, two types of adjacent literature are combined to create an estimate of effectiveness. These are studies that measure the effectiveness of OSHA's enforcement of standards through inspections and studies that measure the impact of similar WVPPs in healthcare facilities.

Regarding the literature measuring OSHA's enforcement, Haviland et al. (2012) found through statistical analysis of Pennsylvania manufacturing data that OSHA enforcement reduced injuries by 11 per 10,000 workers. A similar statistical analysis of the mining industry at a national level found that OSHA enforcement reduced injuries by 7 per 10,000 workers (Gray & Scholz, 1993). Lastly, an RCT of statewide data in California found that enforcement of standards reduced workplace injuries by 9.9 per 10,000 workers (Levine et al., 2012). The estimated impacts are consistent with broader literature claiming that enforcement mechanisms are typically OSHA's most effective method for protecting workers (ELI, 2016; Fairfax, 2020; Michaels, 2020).

Regarding literature measuring the impact of WVPPs, a quasi-experimental study at the hospital level in California found a comprehensive WVPP, nearly identical to the requirements of WVPP in the standard, reduced injury from WPV by 18 per 10,000 workers (Okundolor, 2013). Additionally, a hospital-level quasi-experimental study in California found the use of a 15-step WVPP with similar baseline requirements to the OSHA standard, but additional requirements of staff check-ins reduced injury from WPV by 17.8 per 10,000 workers (Escue, 2013). Lastly, a statistical analysis of WVPPs similar to the requirements of the standard but emphasizing security implemented at the hospital level in Pennsylvania found the measures reduced injury from WPV by 14 per 10,000 workers (Henderson et al., 2014).

To estimate the impact of Alternative 1. Status Quo – A New Standard, by averaging all literature, it suggests a reduction of injuries by 12.95 per 10,000 workers (Haviland et al., 2012; Henderson et al., 2014; Escue, 2013; Gray & Scholz, 1993; Levine et al., 2012; Okundolor,

2013). There is a fair level of confidence in this estimate because the estimates are grouped around a small range; however, there is a span of industries and levels of intervention, as well as a lack of RCTs (See Appendix C for a detailed breakdown of the estimate and confidence). The timeframe over which this estimate is likely to be experienced is one to two years. The timeframe for the analysis of all the combined literature was at least one year. Furthermore, a statistical analysis of a similar California State Plan standard addressing workplace violence in healthcare found that the reporting of incidents increased within the first year and then showed signs of decreasing in the following year (Doucette et al., 2022).

Useful themes to highlight that arose in other literature is the importance of administrative dedication to spearheading and maintaining each WVPP (Escue, 2013). An author whose study of WVPPs yielded results that were not statistically significant attributed these findings to a lack of administrative acceptance and implementation of the program components (Gillespie et al., 2014). Literature in this area also suggests that implementing WVPPs reduces the underreporting of incidents because it fosters a zero-tolerance for violence culture (Berezdivin, 2008; Giordano, 2017).

Criteria 2. Cost

For OSHA to continue with the production of this new standard, it will require time from the staff in the Directorate of Standards and Guidance (DSG). The process for creating standards is long, and OSHA emphasizes the importance of estimating industry impact for every portion of a new standard. Much of the time of staff in the DSG is spent performing research to understand impact and creating cost-benefit analyses. In addition, DSG has a lengthy internal review process and allows public comments to ensure accuracy, but the additional review requires more time (OSHA, n.d.; 2012). To complete the standard in the initial year of the timeline of this alternative, it will require an estimated 50% of the time of six employees in DSG. Furthermore, once the standard is published, all 853 CSHOs will need to review the new regulations to prepare for inspections of healthcare facilities (AFL-CIO, 2024). This is estimated to take an eight-hour day. All costs are presumed one-time. Using applicable wages and benefits, **this alternative is estimated to cost $658,953.05 for OSHA to implement** (See Appendix C for calculations).

The estimated cost for healthcare facilities to comply with the requirements of the standard is derived from the PIRFA produced by OSHA. In this analysis, costs are averaged across all

hospital sizes. Healthcare facilities will need to pay for administrative and patient care staff to develop a WVPP, conduct a facility-wide hazard assessment, purchase and install new environmental safety items, train staff who interact with patients, and create a system for recording violent incidents. In addition to the initial costs of implementing these actions, there will be ongoing costs for evaluating the WVPP, re-training staff, and maintaining the record-keeping system. OSHA estimated that 300,447 healthcare facilities will be required to comply with the standard, ranging from large hospitals to small community clinics. **The cost of compliance per facility is $7,399.61**, estimated over 3 years. Larger or smaller healthcare facilities may incur higher or lower costs (See Appendix C for a detailed breakdown of OSHA's cost estimation process and further discussion on facility size impact on cost) (OSHA, 2023).

Criteria 3. Feasibility

The implementation of this alternative relies on OSHA to publish the standard. Taking into consideration the near completion of the standard and the number of years OSHA employees have spent developing the standard, it is feasible the standard will be published. However, there is an aspect of uncertainty as this report is written within the first few months of the second Trump administration. This is a Republican administration, and there are examples of Republican-identifying politicians advocating for reeling back federal regulations- even so far as to call for the abolishment of OSHA altogether (Dumain, 2024; Surma, 2025). The newly appointed Labor Secretary Lori Chavez-DeRemer and Assistant Secretary of Labor for Occupational Safety and Health Amanda Wood Laihow have not provided any indication of their stance on moving forward with the standard (Ferguson, 2025).

Considering the perspective of healthcare facilities, many may be opposed to the standard. Recently, there has been growing concern in healthcare management that excessive standards and requirements increase the administrative labor burden unproductively (Committee on Education and Workforce, 2022; OSHA Blog, 2022). In the context of this standard, however, this sentiment is met with direct opposition from associations that represent workers, such as National Nurses United, which has consistently called for regulation of the issue of workplace violence (NNU, 2024).

Taking into account differing stakeholder perceptions, **the feasibility of this alternative is ranked as medium.**

Alternative 2. Increasing Inspections

Criteria 1. Effectiveness

To determine the potential impact of this alternative on addressing WPV in healthcare, measures are drawn from the same literature used to estimate OSHA enforcement impact in Alternative 1: Status Quo – A New Standard (Gray & Scholz, 1993; Haviland, 2012; Levine, 2012). Although these are different alternatives, they both leverage the same key action OSHA can take: enforcing compliance with regulations.

Derived from a combination of RCT and statistical analysis at both the state and national levels across various industries, literature indicates Alternative 2. Increasing Inspections **is estimated to reduce injury at a rate of 9.3 per 10,000 workers** (Gray & Scholz, 1993; Haviland, 2012; Levine, 2012). The same confidence assessment applies to this alternative; while the small range of estimates is favorable, there is a lack of RCTs and literature overall. Additionally, the study level of interventions and industries are not aligned, which diminishes confidence in the assessment. More literature regarding the impact of enforcement in the healthcare industry would improve the confidence assessment (See Appendix D for a breakdown of effectiveness).

This estimate rate is lower than the estimate produced for Alternative 1 because it does not include the healthcare industry-specific literature surrounding WVPPs, highlighting that this alternative lacks the specific requirements that employers in the healthcare sector must follow.

A useful theme to note across the literature is that inspections on their own are impactful, but inspections resulting in penalties can be even more impactful. Foley et al. (2012) found that workplaces that were inspected and subsequently received a penalty for violations saw a 16 percentage point more decline in worker compensation claim rates than workplaces that were inspected and did not receive penalties. OSHA's ability to enforce regulation can be effective, and it is important to understand the intricacies contributing to the impact.

Criteria 2. Cost

The potential costs incurred for OSHA to carry out Alternative 2 are OSHA DSG staff time to plan, prepare and release the NEP, and the time spent per CSHO inspecting healthcare facilities. OSHA staff cost for creating the NEP is a one-time expense in the initial year. DSG requires

extensive regulatory impact analysis to understand the tradeoffs of increasing inspections in one industry at the cost of decreasing inspections in another (OSHA, 2012; OSHA, n.d.). The language of the NEP needs to be drafted as well. Given the labor burden, in the initial year it is estimated to take 50% of the time of 4 staff in the DSG at OSHA. In addition to DSG staff, the cost of 853 CSHO time to inspect healthcare facilities rather than other industries is estimated for three years using annual wages and benefits, and the percent of annual inspection increase as a basis for calculation. In total, for three years, **the cost for OSHA to carry out this alternative is $14,088,220.34** (See Appendix D for the cost calculations)**.**

The cost of compliance for healthcare facilities is low in this alternative. The NEP would not require any actions to be taken by healthcare facilities as it is not a standard. The only cost healthcare facilities would incur is the labor burden of a healthcare administrative staff to walk around with the CSHO during an inspection. Healthcare facility inspections can take 1 day to nearly a week, depending on facility size (OSHA Blog, 2022). This estimates an annual two eight-hour days of time required, using annual wages and benefits. **The cost of compliance per healthcare facility for three years is $2,575.79** (See Appendix D for the cost calculations)**.**

Criteria 3. Feasibility

OSHA has leveraged the use of NEPs to increase inspections in the healthcare industry, specifically during COVID-19, to ensure proper protective equipment use (OSHA, 2022). Indicating an NEP for WPV in healthcare is feasible. However, there is a limited number of CSHOs, so their time is valuable (Fairfax, 2020; ELI, 2016; Michaels, 2020). Increasing inspections in healthcare directly correlate with decreasing inspections in other industries, and OSHA already inspects healthcare facilities at a rate of 12% of total inspections annually (Abyde, 2022). In addition, taking into account the recent transition in administrations, passing new regulations is uncertain and the party affiliation of the new administration is not supportive of increasing government regulations (Committee on Education and Workforce, 2022; Dumain, 2024; Surma, 2025). Therefore, the feasibility of this alternative being approved is less likely.

Regarding the perspectives of healthcare facilities, inspections are typically viewed as time-consuming and, therefore, not as favorable (OSHA Blog, 2022). Workers and unions or associations representing them may favor any increase in regulation to address WPV, however, there has been support for regulations creating permanent change, not temporary measures. In

response to OSHA's Covid-19 NEP, the New York State Nurses Association and other healthcare unions advocated for permanent policy protections instead (NYSNA, 2022).

Overall, **this alternative is ranked low in feasibility.** Increasing inspections is assumed to be an unfavorable alternative to most stakeholders.

Alternative 3. Training and Strategic Partnership

Criteria 1. Effectiveness

Findings from applicable literature are used to derive an estimated impact of Alternative 3. Training and Strategic Partnership on reducing injury from WPV. There is a lack of literature that measures specifically a combined training and strategic partnership program, and a OSHA Strategic Partnership in general. The estimated impact of this alternative relies on literature measuring the impact of WPV prevention training in healthcare facilities.

Gillam et al. (2014) conducted a quasi-experimental study at the hospital level in Texas, finding that implementing WPV prevention training after one year decreased injuries by 22 per 10,000 workers. In an RCT at the facility level in Ohio, injuries were reduced by a rate of 14.9 per 10,000 following online training workers (Irvine et al., 2012). This literature is useful for suggesting the potential effectiveness of this alternative; however, the confidence in the transferability of these results to this alternative is low. The estimates range is not as close together as estimates used in other alternatives, and the intervention level assessed is at the local level. In contrast, the program in this alternative is the national level.

Another concern with estimating the effectiveness of this alternative is that the training is optional for healthcare facilities to adopt. This means that not all facilities may adopt the training. To account for this uncertainty, the estimated percent of adoption is taken into account using the current estimate of employers who currently provide WPV training – 62.8% (NNU, 2024). Overall, **Alternative 2 is estimated to reduce injury from WPV by 11.59 per 10,000 workers (**See Appendix E for breakdown**).**

Furthermore, there is no applicable literature to understand how the addition of strategic partnerships will increase the extent of employer adoption, however, literature broadly applicable to outreach programs suggests partnerships are a useful strategy to supplement OSHA's inability

to inspect and provide resources to all workplaces (Fairfax, 2020). In addition, regardless of length or method of training, the literature overwhelmingly suggests training is very useful for improving healthcare worker confidence in handling violent situations (Khan et al., 2021; de la Fuente et al., 2019; Chang, 2022; Kumari et al, 2022; Somani et al., 2021) .

Criteria 2. Cost

The anticipated costs OSHA may incur in implementing this alternative include OSHA DCSP staff costs for creating the training and strategic partnerships, and technology costs for hosting the training on OSHA's website. Given the expansive material to cover and the time required, training creation will require 50% of the time for four employees in DCSP to create the training program, and 75% of the time of one employee in DCSP to form and manage the strategic partnerships. These are one-time costs in the initial year of implementation, using annual wages. There will also be the cost to host the training on OSHA's website- this is estimated to take a small percentage off the allocated technology budget in OSHA's overall budget. This technology cost is calculated for three years, estimating a 1% use of the technology allocation in OSHA's FY2025 appropriated budget (OSHA, 2025). In total, **this alternative is estimated to cost OSHA $1,202,902.74** (See Appendix E for cost calculations).

The cost for healthcare facilities to comply with this alternative is derived from the labor time of employees to take the training. All healthcare facility staff will be able to take the training. Training for patient care staff is 3 hours, and training for administrative staff is 1 hour. Following a similar structure to the calculation of training costs in the OSHA PIRFA, this calculation assumes 75% of healthcare staff are patient care and 25% are administrative (OSHA, 2023). There is an ongoing cost each year to retrain employees, assuming 50% of the time for retraining as in the initial year. Using OSHA's estimated industry statistics, cost is measured per healthcare facility. Estimated for three years, **the cost per healthcare facility is an estimated $12,293.47** (See Appendix E for cost calculations).

Criteria 3. Feasibility

Training to protect against health and safety risks in any industry is a resource that OSHA advocates for on its own website. Additionally, OSHA hosts publicly available online training on its website similar to this alternative, indicating it is feasible to implement. Regarding the

strategic partnership aspect of the alternative, this relies on a large program within OSHA, of which success stories are displayed across the OSHA website (OSHA, n.d., 2024). These programs are optional and do not create more regulations, therefore it is feasible these programs would have OSHA leadership support for implementation.

Regarding healthcare facilities and unions representing workers, training is sometimes viewed as time-consuming yet necessary. The optional aspect of this alternative is likely favored by healthcare facilities, allowing them to decide how best to implement it on their own, which could mean lower rates of takeup. The unions and associations representing workers, who will be the strategic partners, likely view strategic partnerships more favorably as they allow involvement in the regulatory process. However, the lack of permanent policy change may decrease favorability among workers and unions and associations representing them (NYSNA, 2022; Salmon, 2021; Committee on Education and Workforce, 2022).

Given the presumed wide stakeholder support for training and strategic partnerships, **this alternative ranks high in feasibility**.

Outcomes Matrix

		Alternative 1. Status Quo – A New Standard	**Alternative 2. Increasing Inspections**	**Alternative 3. Trainings and Strategic Partnerships**
Effectiveness		Decrease injuries by 12.95 per 10,000 workers	Decrease injuries by 9.3 per 10,000 workers	Decrease injuries by 11.59 per 10,000 workers
Cost	*Cost to OSHA*	$658,953.05	$14,088,220.34	$1,202,902.74
	Cost of Compliance per Healthcare Facility	$7,399.61	$2,575.79	$12,293.47
Feasibility		Medium	Low	High

Recommendation

Workplace violence in the healthcare industry happens every day. An immediate response and support is needed, but it is also important to create lasting change in the industry. **OSHA should pursue alternative 1. Status Quo - Workplace Violence in Healthcare Standard.** This would create a broad and lasting legal requirement of a certain level of protection for healthcare workers. Literature on the issue emphasizes the need for legislation to establish nationwide protections for healthcare workers (AFl-CIO, 2024; NNU, 2024; MHA, 2023). In addition, literature highlights that healthcare facility administration's prioritizing worker safety through methods such as creating WVPP as required in OSHA's Standard is essential for lasting impact (Arnetz et al., 2017; Escue et al., 2023; Gillespie et al., 2014; Kumari et al, 2022; Okundolor et al., 2020).

Determining the best alternative for OSHA to pursue is difficult and many tradeoffs exist. Alternative 1. Status Quo – A New Standard has been in production since 2016, and the years of careful analysis and research has formulated a comprehensive set of protections for healthcare workers that would be legally required (OIRA, 2025; OSHA, 2012). However, Alternative 3. Training and Strategic Partnerships also ranks well in effectiveness, cost, and feasibility. Training provides additional resources and support to an overworked and undervalued industry experiencing a painful issue, yet it is limited as an optional program and concern exists around the rate of uptake. A standard creates a permanent legal requirement that healthcare employers address this issue at an administrative level, demonstrating a level of care and solidarity for healthcare workers.

Implementation Analysis

For Alternative 1. Status Quo- A New Standard to be implemented to the fullest extent of effectiveness there are a number of steps to be taken first, each with barriers.

First, the Directorate of Standards and Guidance in OSHA needs to make a strong case for the standard to continue to be published to Labor Secretary Chavez-DeRemer and Assistant Secretary of Labor for Occupational Safety and Health Wood Laihow. The Labor Secretary and Assistant Secretary then need to approve the continuation of the standard (Ferguson, 2025). If they decide not to continue with the standard, they will likely prolong the scheduled release as

long as possible before an official discontinuation. It is feasible that the Trump Administration advise the newly appointed Secretary and Assistant Secretary to prolong or discontinue the standard (Surma, 2025). In that case, OSHA should pursue Alternative 3: Training and Strategic Partnerships.

If all levels of leadership approve the standard to continue, then OSHA's DSG should prepare and release the proposed standard at the scheduled time. This analysis assumes there have been very few, if any, changes made to the measures in the previously released version of this standard (the version detailed in this report). If there are major content changes that would drastically decrease the effectiveness of the standard, OSHA should also pursue Alternative 3: Training and Strategic Partnerships.

Following the public release of the proposed standard, there will be a required period of public comment followed by a review of comments and potential revisions to the standard. If the proposed standard is released in the version previously released, there are not likely to be substantial revisions in the final comment period that would overly impact effectiveness. After this period, the standard then needs to be published as a final rule (OIRA, 2025; OSHA, 2012).

Once published as a final rule, the standard will be learned and implemented by CSHOs across the nation. For full effectiveness, healthcare facilities must know of the standard and implement the requirements. To leverage the full force of OSHA's enforcement mechanism, CSHO's must continue to inspect healthcare facilities and enforce compliance with the new standard through giving out penalties for violations of requirements (OSHA, n.d.). This step of implementation faces complex barriers. The understaffing of CSHOs presents logistical challenges in adequately monitoring the safety and health of healthcare facility environments for workers (ELI, 2016; Michaels, 2018; AFL-CIO, 2024; Salmon, 2021). In addition, in the healthcare industry, a major challenge is the normalization of violence as part of the job, which discourages staff from reporting incidents or engaging in preventive measures (Arnetz et al., 2015). To ensure these barriers are not impeding the effectiveness of the standard, there should be continuous tracking and review of WPV injuries in healthcare. If the standard is found to have little to no impact, OSHA should continue with Alternative 3: Training and Strategic Partnerships.

Words: 8,000

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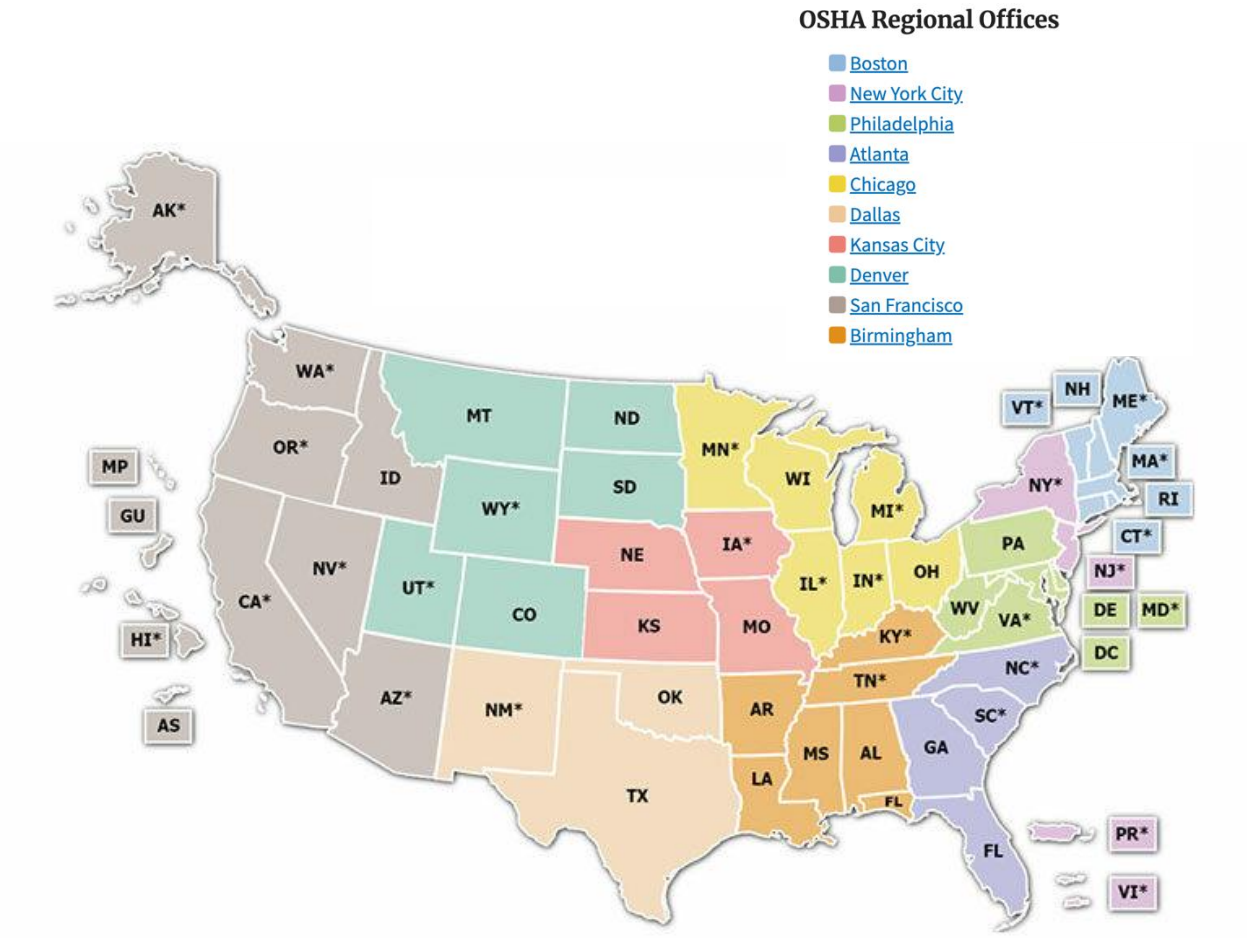
Appendices

Appendix A. OSHA Coverage

Federal OSHA covers workers in all states except state and local government workplaces, workplaces in the 22 State Plans, and some workplaces in seven partial coverage State Plans. In State Plans, states run their own occupational health and safety programs but must continuously adopt similar or identical regulations to Federal OSHA (OSHA, n.d.).



* This is one of the 29 OSHA-approved State Plans. Twenty-two State Plans (21 states and Puerto Rico) cover both private and state and local government workplaces. The other seven State Plans (Connecticut, Illinois, Maine, Massachusetts, New Jersey, New York, and the Virgin Islands) cover state and local government workers only.

(OSHA, n.d.)

Appendix B. Federal OSHA Civil Penalties for Violations

Type of Violation	Penalty Minimum	Penalty Maximum
Serious	$1,221 per violation	$16,550 per violation
Other-Than-Serious	$0 per violation	$16,550 per violation
Willful or Repeated	$11,823 per violation	$165,514 per violation
Posting Requirements	$0 per violation	$16,550 per violation
Failure to Abate	N/A	$16,550 per day unabated beyond the abatement date [generally limited to 30 days maximum]

(OSHA, 2025)

Appendix C. Alternative 1 Analysis

Alternative 1. Status Quo – A New Standard: Criteria 1. Effectiveness

Study	Method	Location	Time	Industry	Findings
Haviland et al., 2012	Statistical Analysis Quasi-Experimental	Pennsylvania - statewide	1998–2005	Manufacturing	Decrease injuries by 11 per 10,000 workers
Levine et al., 2012	RCT	California	2012	All industries	Decrease injuries by 9.9 per 10,000 workers
Gray & Scholz, 1993	Statistical Analysis Quasi-Experimental	Nation-wide	2004-2009	Mining	Decrease injuries by 7 per 10,000 workers
Okundolor et al., 2013	Statistical Analysis Quasi-Experimental	Hospital level - Los Angeles, California	2016-2018	Hospital staff	Decrease injuries by 18 per 10,000 workers
Henderson et al., 2013	Statistical Analysis Quasi-Experimental	Hospital level - Pittsburgh, Pennsylvania	2011-2012	Hospital staff	Decrease injuries by 14 per 10,000 workers
Escue et al., 2013	Statistical Analysis Quasi-Experimental	Hospital level- San Diego, California	2018-2020	Hospital staff	Decrease injuries by 17.8 per 10,000 workers
Average:	**Quasi-Experimental and RCT**	**State, nation, hospital level**	**1998-2020**	**All industries, manufacturing, mining, hospital staff**	**Decrease injuries by 12.95 per 10,000 workers**

Confidence Assessment: Findings are in a tight range across studies, and support conclusions from other literature on the topic, supporting, however, the lack of RCTs or more research in general. and reliance on quasi-experimental findings at a state and hospital level brings the confidence assessment down.

Alternative 1. Status Quo – A New Standard: Criteria 2. Cost

Cost to OSHA:

One Time Cost				
Category	**Specification**	**Components**	**Cost Calculation**	**Cost in 2025 USD**
Staff	50% of one year of work for 6 Federal OSHA FTEs in the Directorate of Standards and Guidance	Federal OSHA Employee Avg. Annual Wage = $105,225 (DOL, 2025) FTE Benefits = 31.1% of Annual Wage (BLS, 2024)	(0.5 time x 6 FTE) x ($105,225 Annual Wage + (0.311 Benefits Share x $105,225 Annual Wage))	$413,849.93
	8 hours of time for 853 Federal CSHOs	Avg. Annual Wage of Federal CSHOs = $80,000 (OSHA Outreach, 2024) FTE Benefits = 31.1% of Annual Wage (BLS, 2024)	(($ 80,000 CSHO Wage + (31.1% of $80,000 for Benefits)) x (1 work day / 365))) x 853 CSHOs	$245,103.12
Total				**$658,953.05**

Cost of Compliance per Healthcare Facility

Estimation of cost to healthcare facilities for compliance with the potential WPV in Healthcare and Social assistance standard are directly sourced from OSHA's Preliminary Initial Regulatory Flexibility Analysis (PIRFA). A copy of the PIRFA is publicly available online within the Small Business Advocacy Review (SBAR) Panel response to the document and comments on the potential standard. The chart below provides OSHA's estimated costs per facility for compliance with each aspect of the standard, along with a brief description of how OSHA derived the estimate in the PIRFA.

One Time Cost			
Standard Requirement	**Simplified Description of OSHA's Calculation Process**	**PIRFA Estimated Cost in 2019 USD**	**2025 USD**

WVPP	The labor burden to create a WVPP is estimated to be distributed as 75% administrative staff and 25% patient care/contact staff. For a large healthcare facility it is estimated to take 100 hours in the first year. Labor burden for other facilities was scaled down from this measure, using employee numbers as ratio metric. Labor burden is multiplied by wages (benefits incorporated) to determine costs. Costs are calculated per various types and sizes of facilities, and averaged for an overall estimate.	$161.47	$204.69
Facility-wide Hazard Assessment	A facility-wide hazard assessment is estimated to take each facility 20 minutes per bed, with the assumption of labor burden distributed as 75% administrative staff and 25% patient care/contact staff. A review of previous reported violent incidents is added into the cost, assuming 100% administrative staff burden- BLS statistics of reported incidents per facility type are used to determine time needed for review per facility. In total, first year labor burden for a large facility is estimated to be 100 hours. Labor burden for other facilities was scaled down from this measure, using employee numbers as ratio metric. Labor burden is multiplied by wages (benefits incorporated) to determine costs. Costs are calculated per various types and sizes of facilities, and averaged for an overall estimate.	$157.75	$199.97
Control Measures	Cost is estimated by multiplying the purchasing and installation cost for items such as alarm systems, paging systems, lights, and weapon detectors per facility by the estimated likelihood of each facility type requiring these items. The percentages ranged from 5-25%. Cost per facility is averaged to get one estimate.	$259.69	$329.20

Training	It is assumed only patient care/contact staff will receive training. It is also assumed 65% current compliance- which is factored into this cost estimate. On average, patient care/contact staff account for 75% of total staff. For large hospitals, it is assumed they will hire full time trainers, whereas all other facilities are assumed to hire outside trainers. Based on a measure of percent of time spent with patients, some patient care/contact staff receive 8, 4 or 2 hours of training at first, and 4, 2 and 1 hours annually. Using these assumptions, cost is determined by using estimates of patient care/contact staff size per facility then averaged across facilities.	$2,250.88	$2,853.32
Record Keeping and Investigations	It is estimated that investigating incidents of WPV require an average of 4 hours. It is also estimated burden for recording incidents in a system takes 0.8 hours per year assuming 100% administrative staff burden. Using 2019 estimated of WPV occurrence per facility and wages cost is estimated per facility then averaged.	$182.00	$230.71
Ongoing Cost			
WVPP Year 2	The estimated labor hours to upkeep the plan is at least 1 hour annually, scaling up as necessary for larger facilities using the same process as in the initial year. Assuming time is distributed as 75% administrative staff, and 25% patient care/contact staff. This estimate reflects an inflation rate of 2.9%.	$47.63	$60.38
Training Year 2	It is assumed subsequent years of training require about 50% less cost and labor burden. This cost is derived using the same methods in the initial year, but with modified labor hours and an inflation rate of 2.9% applied.	$1,157.63	$1,467.47
Record Keeping and Investigations Year 2	It is assumed WPV incidents will decrease following implementation of the measures in this standard, however for the cost calculation for this component of the standard OSHA assumes the same rates and inputs as in the initial year. This cost is derived using the same methods in the initial year, but with an inflation rate of 2.9% applied.	$187.29	$237.42
Workplace Violence	This cost is derived from applying a 2.9% inflation rate on the WVPP Year 2 estimate.	$49.01	$62.13

Prevention Plan Year 3			
Training year 3	This cost is derived from applying a 2.9% inflation rate on the Training Year 2 estimate.	$1,191.20	$1,510.02
Record Keeping and Investigations Year 3	This cost is derived from applying a 2.9% inflation rate on the Investigation Year 2 estimate.	$192.72	$244.30
Total		$5,837.27	**$7,399.61**

(OSHA, 2023)

The estimates in this table have been adjusted to measure out for 3 years, taking into account inflation therefore they may appear different from the original OSHA PIRFA.

Context for OSHA PIRFA Estimates

The cost estimates in the PIRFA are lower than other estimates in this report and the estimates of the Congressional Budget Office. In total, OSHA estimated 1.2 billion in costs of compliance for the 300,447 healthcare facilities in scope. The Congressional Budget Office (CBO) produced a cost estimate for HR 1309 Workplace Violence Prevention for Healthcare and Social Service Workers Act in 2019. This act did not pass, but if it had, it would have required OSHA to publish the Workplace Violence in Healthcare and Social Assistance standard on an expedited timeline. CBO estimated the OSHA Workplace Violence in Healthcare and Social Assistance standard would incur compliance costs for healthcare facilities of 1.4 billion in the initial year, and 1.36 billion each year after. Little information is provided on the estimation process for the CBO (CBO, 2019). However, reasons for OSHA's lower estimate could be their consideration of small entities and the use of averaging across large to very small facilities. The charts below are characteristics of the healthcare facilities that are the basis for OSHA's estimated costs. Large facilities have upwards of 200 beds and 1,000 employees, whereas small facilities have below 50 beds and 200 employees (OSHA, 2023).

Healthcare facilities:	300477
Percent that are small facilities (serving less than 50,000 people or annual revenue below $41M)	84.88%

(OSHA, 2023)

Hourly Wages (with benefits included) in 2019 USD		
Large facilities (hospitals)	Patient client care/contact staff	$53.01
	Administration	$95.37
Small Facilities (community health clinics)	Patient client care/contact staff	$24.96
	Administration	$55.50

(OSHA, 2023)

Cost Estimates for Facility Size Extremes

OSHA (2023) estimated that the initial total costs of compliance for larger facilities to be $59,202.34 and for smaller facilities $440.50 in 2019 USD.

Industry Breakdown

Setting	NAICS Description	NAICS Code	WPV Injury Rate per 10,000 Workers
Residential and Behavioral Health Facilities	Offices of Physicians, Mental Health Specialists	62112	26.6
	Offices of Mental Health Practitioners (Except Physicians)	621330	10.5
	Outpatient Mental Health and Substance Abuse Centers	621420	3.9
	Psychiatric hospitals	622210	124.9
	Residential Intellectual and Developmental Disability Facilities	623210	41.7
Hospitals, other than mental health	General Medical and Surgical Hospitals	622110	9.7
	Freestanding Ambulatory Surgical and Emergency Centers	621493	3.9
	Specialty Hospitals	622310	12.8
Residential Care Facilities	Nursing Care Facilities	623110	14.9
	Continuing Care Retirement Communities	623311	8.5
	Assisted Living Facilities for the Elderly	623312	8.5
	Other Residential Care Facilities	623990	61
Home Healthcare Services	Home Health Services	621610	4.1
	Services for Elderly and Persons with Disabilities	624120	14.7
Social Assistance	Child and Youth Services	624110	29.2
	Other Individual and Family Services	624190	7.6
	Community Food Services	624210	7.5
	Temporary shelters	624221	11.8

	Other Community Housing Services	624229	11.8
	Emergency and Other Relief Services	624230	7.5
	Vocational Rehabilitation Services	624310	17
Emergency Medical Services	Ambulance Services & EMTs	621910	3.4
	EMTs	561990	2

(OSHA, 2023)[4]

[4] OSHA sourced the information from 2021 BLS statistics.

Appendix D. Alternative 2 Analysis

Alternative 2. Increasing Inspections: Criteria 1. Effectiveness

Study	Method	Location	Time	Industry	Findings
Haviland et al., 2012	Statistical Analysis Quasi-Experimental	Pennsylvania - statewide	1998–2005	Manufacturing	Decrease injuries by 11 per 10,000 workers
Levine et al., 2012	RCT	California	2012	All Industries	Decrease injuries by 9.9 per 10,000 workers
Gray & Scholz, 1993	Statistical Analysis Quasi-Experimental	Nation-wide	2004-2009	Mining	Decrease injuries by 7 per 10,000 workers
Average:	**Quasi-Experimental and RCT**	**Nation and Statewide**	**1998-2012**	**All industries, manufacturing, mining**	**Decrease injuries by 9.3 per 10,000 workers**

Confidence Assessment: Findings are similar, increasing confidence in results. However, the lack of more RCTs and research in general and reliance on state-level studies lower confidence in the transferability of results.

Alternative 2. Increasing Inspections Criteria 2. Cost

Cost to OSHA

One Time Cost				
Category	**Specification**	**Components**	**Cost Calculation**	**Cost in 2025 USD**
Staff	50% of one year of work for 4 Federal OSHA FTEs in the Directorate of Standards and Guidance	Federal OSHA Employee Avg. Annual Wage = $105,225 (DOL, 2024) FTE Benefits = 31.1% of Annual Wage (BLS, 2024)	(0.5 time x 4 FTE) x ($105,225 Annual Wage + (0.311 Benefits Share x $105,225 Annual Wage))	$275,899.95
Ongoing Cost				

Staff	Yearly Opportunity cost of 5% Time of 853 CSHOs for 3 years of implementation	CSHO Annual Wage = $80,000 (OSHA Outreach, 2024)	0.05 Time ($80,000 Wage + (.311 Benefits x 80,000 Wage))	$4,473,132.00 (Initial year)
		Benefits = 31.1% of Wages (BLS, 2024)	Year 2: $4,473,132.00 x 2.9% Estimated Rate of Inflation Based off of 2024	$4,602,852.83 (Year 2)
		2024 Inflation = 2.9% (BLS, 2024)	Year 3: $4,602,852.83 x 2.9% Estimated Rate of Inflation Based off of 2024	$4,736,335.56 (Year 3)
Total				**$14,088,220.34**

Cost per Healthcare Facility

Category	Specification	Components	Cost Calculation	Cost in 2025 USD
One-time Cost (if given a penalty, not included in total)				
Penalty	Penalty amount if cited for violation	Precedent for Penalty Amount = $17,000 in 2021 (McCormack, 2022)	$17,000 x Inflation	$20,150.43
Ongoing Cost				
Staff	Yearly 2 8-hour days of Time of 1 Hospital Administration FTE for 3 Years of Implementation	Hospital Administration FTE Annual Salary = $116,122.53 (BLS, 2024)	($116,122.52 + ($116,122.52 x 0.311)) x 0.01 Time	$834.17 (Initial year)
		FTE Benefits = 31.1% of Annual Wage (BLS, 2024)	$2,892.50 x 2.9% Inflation	$858.36 (Year 2)
		2024 Inflation = 2.9% (BLS, 2024)	$2,976.38 x 2.95 Inflation	$883.26 (Year 3)
Total				**$2,575.79**

Appendix E. Alternative 3 Analysis

Alternative 3. Training and Strategic Partnerships: Criteria 1. Effectiveness

Study	Method	Location	Time	Industry	Findings
Gillam et al., 2014	Statistical Analysis Quasi-Experimental	Hospital level - Austin, Texas	2012-2013	Hospital Staff	Decrease injuries by 22 per 10,000 workers
Irvine et al., 2012	RCT	Six hospitals in Cincinnati, Ohio	2012	Hospital Staff	Decrease injuries by 14.9 per 10,000 workers
Average:	**Quasi-Experimental and RCT**	**City, hospital level**	**2012-2013**	**Hospital Staff**	**Decrease injuries by 18.45 per 10,000 workers**

Confidence Assessment: The lack of more research in general and at the state and hospital levels of studies makes confidence in the application of these findings low. Furthermore, the current estimated rate of training or workplace violence in the healthcare industry is about 62.8%. Assuming not every healthcare facility will implement the training, this percentage has been applied to the effectiveness findings of this alternative to reflect the uncertainty around the take-up rate.

Alternative 3. Training and Strategic Partnerships - Criteria 2. Cost

Cost to OSHA

One Time Cost				
Category	**Specification**	**Components**	**Cost Calculation**	**Cost in 2025 USD**
Staff	50% of Time of 4 FTE, 75% of Time of 1 FTE	Federal OSHA Employee Avg. Annual Wage = $105,225 (DOL, 2024) Benefits = 31.1% of Wages (BLS, 2024)	(0.5 Time x 4 FTE) x ($105,225 Wage + ($105,225 Wage x 0.331 Benefits)) + (0.75 Time x 1 FTE) x ($105,225 Wage + ($105,225 Wage x 0.331 Benefits))	$385,149.81
Ongoing Cost				

Technology	Yearly .05% of the Technical Support Budget for the server use, video production materials, and other technology involved in hosting a video training on DOL's webpage for 3 years of implementation	2025 Technical Support Budget = $26,483,000 (OSHA, 2025)	$26,483,000 Budget x 0.01 Use	$264,830.00 (Initial Year)
		2024 Inflation = 2.9% (BLS, 2024)	$1,324,150 x 2.9% Estimated Rate of Inflation Based off of 2024	$272,510.07 (Year 2)
			$1,362,550 x 2.9% Estimated Rate of Inflation Based off of 2024	$280,412.86 (Year 3)
Total				**$1,202,902.74**

Cost to Healthcare Facilities

One Time Cost				
Category	**Specification**	**Components**	**Calculation**	**Cost in 2025 USD**
Staff	3 hours of time for patient care staff, 1 hour of time for administrative staff. Assuming 13,952,827 FTE healthcare workers, 75% are patient care staff, and 25% are administrative staff (OSHA, 2023)	Average annual wage of patient care staff = $184,340 (BLS, 2024)	(((13952827x0.75)x(0.375/365)x(184340+(184340x.311))) +((13952827x.25)x(0.125/365)x(116122.53+(116122.538.311))))/300447	$6,014.65 (Initial Year)
		Average annual wage of administrative staff $116, 122.53 (BLS, 2024)		
		Benefits = 31.1% of Wages (BLS, 2024)		
Ongoing				
Staff	The same as in the initial year, except assuming 50% reduction of hours for retraining (OSHA, 2023)	Average annual wage of patient care staff = $184,340 (BLS, 2024)	(6014.65*0.5)x1.029	$3,094.54 (Year 2)
		Average annual wage of		

		administrative staff $116, 122.53 (BLS, 2024)		
		Benefits = 31.1% of Wages (BLS, 2024)	(3094.54)x1.029	$3,184.28 (Year 3)
		2024 Inflation = 2.9% (BLS, 2024)		
Total				**$12,293.47**