California Medical Association
Physicians dedicated to the health of Californians

February 27, 2015

Robert Nakamura
Senior Safety Engineer
DOSH Research and Standards Health Unit
Cal/OSHA
Elihu Harris State Building
1515 Clay Street
Oakland, CA 94612

Dear Mr. Nakamura:

The California Medical Association (CMA) respectfully submits the following comments for consideration related to the first draft of the proposed regulations on workplace violence prevention in healthcare. CMA is an advocacy organization that represents more than 39,000 California physicians. Dedicated to the health of Californians, CMA is active in the legal, legislative, reimbursement and regulatory areas on behalf of California physicians and their patients.

CMA appreciates Cal/OSHA's effort to address the issue of workplace violence in healthcare settings and the measures that are being taken to solicit input from all stakeholders. The purpose of this letter is to provide information on how these draft regulations would likely impact physicians and their medical practices, as well as to provide recommendations for amending the next version of this document.

Background

Organized medicine has long supported the development of policies to improve workplace safety in healthcare settings. CMA supports the development of model safety plan for office-based physicians to address violence in the workplace, as well as the inclusion of physicians as members of hospital safety committees to address security issues within the hospital. The American Medical Association (AMA) also encourages all healthcare facilities to adopt policies to reduce and prevent all forms of workplace violence and abuse; to develop policies to manage reported occurrences of workplace violence and abuse; and advocates that training courses on workplace violence prevention and reduction be more widely available.

CMA has been participating in Cal/OSHA's Workplace Violence Prevention Advisory Committee and has previously provided oral comments on how these regulations may impact physician office-based practices.

Physician office-based practices are not subject to state health facility licensing laws and physicians may practice medicine under the plenary medical license issued by the Medical Board of California. As such, physicians practice in a wide range of settings. While many physicians are practicing in large multi-specialty groups, there are still many physicians practicing alone or in small medical groups where the staff (besides the physician employer) is limited to one or two employees. There is also variation among physician practices in California with regard to a range of factors that impact workplace safety including the number of physicians and staff, patient mix, availability of practice management and community resources, and geographic location.

At this time, there is very little data on the extent to which physician office-based practices in California are exposed to workplace violence. There have been a handful of high-profile cases in which physicians were shot or assaulted in their offices and anecdotal reports from medical offices regarding angry patients and families. While there is a general view that due to the lower patient acuity experienced in medical offices (as opposed to hospitals), the level of workplace violence in physician offices is lower than in other types of health facilities, there is little evidence to substantiate this hypothesis.

Comments on the Discussion Draft

CMA recognizes that the proposed regulations are still being developed and are in a very early draft. However, we would like to take this opportunity to offer initial feedback on the draft and look forward to reviewing future drafts and offering additional feedback.

Definitions. There are several terms defined in the Definitions section that are not used anywhere else in the document. As such it is difficult to determine if the terms are being defined appropriately. Some examples:

The draft regulations define "medical specialty practice" as a medical practice other than primary care, general practice or family medicine. However, the purpose of defining medical specialties is unclear as the term is not referenced in any other part of the document. Depending on the purpose of defining medical specialties in this document, an alternate definition for "medical specialty" may be more appropriate. The definition of a "primary care" practice can include specialties such as pediatrics and OB/GYN, and it is unclear whether that would be included in the definition of "medical specialty practice".

The draft regulations also define "Physician or other licensed health care professional (PLHCP)", but the term is not used elsewhere in the draft. This is a very broad definition and may need to be revised depending on how it is used in the regulations.

Development of the Workplace Violence Prevention Plan. The proposal states that each employer covered by Section 3203 shall maintain an effective written workplace violence plan. The list of elements that need to be included in each plan is extensive and includes procedures for developing, implementing and reviewing the plan; communication; workplace assessments; correction of hazards; post-incident response plans; and training procedures.

Compliance with these proposed regulations as drafted potentially requires significant staff and financial resources as well as access to specialized expertise on workplace violence and security issues. While this may not present a significant challenge for hospitals and other licensed health facilities who have the financial resources and organizational capacity to develop the plan (and indeed may already have a workplace violence prevention plan in place as a licensing or accreditation requirement), physicians and other health care providers practicing in small or solo practices and operating as very small businesses may be challenged to comply with the requirements set forth in this document.

Requiring physicians who employ only a few employees and who may not have the practice management infrastructure to develop extensive workplace violence prevention plans and training processes would place a substantial burden on the practice. Efforts to comply could result in the practice closing down for a few days to develop the plan and provide the training to employees. Patient access to care could also be limited as staff resources are diverted to develop the plan and provide employee training.

CMA recommends that the application of these regulations, with regard to outpatient medical offices, be limited to employers with 5 or more employees. We recommend that Cal/OSHA develop simplified requirements for employers with 5 or fewer employees that provide a less formal mechanism discharging their responsibility to educate employees on workplace violence prevention.

Correction of Workplace Violence Hazards. The proposal outlines corrective measures that can be implemented to address workplace violence hazards. While the measures listed are generally appropriate responses to a hazard, it should be noted that several of the corrective measures would be difficult to implement in a medical office setting. For example:

- In a small medical practice, there is unlikely to be dedicated building security staff or employees who are assigned to respond immediately in the event of a violent incident. Medical office staff would likely contact law enforcement instead.

- The ability to reconfigure facility space or install alarm systems may be limited if the employer is leasing the office space.

It is unclear which corrective actions are expected to be implemented by all facilities versus only licensed health facilities.

Conclusion

These comments highlight the problem of developing highly prescriptive regulations in the absence of more information about the different ways in which violence can arise in various healthcare settings. Codifying an extensive list of the many elements that could theoretically be included in a workplace violence prevention plan may not be as useful as identifying the most important violence prevention and safety issues that need to be addressed in particular healthcare settings. In addition, imposing the same requirements regardless of individual workplace factors (such as size and organizational capacity) is likely to lead to confusion and lower compliance. CMA urges the department to engage in more rigorous data collection on this issue in order to develop clearer regulations that can be implemented and enforced.

As Cal/OSHA moves forward with the development of the workplace violence prevention regulations, we urge the department to consider the wide range of healthcare settings in which these regulations may be applied and the extent to which specific elements of workplace violence prevention plans should be articulated in the regulations. Greater compliance may be achieved if the Cal/OSHA regulations focus on: 1) creating a standard definition of workplace violence; 2) creating a standard reporting mechanism for reporting workplace violence; and 3) incorporate and incident response/analysis component. These actions would provide a foundation to begin collecting data on the nature of violence in the workplace. Cal/OSHA could also develop more detailed advisory guidance on developing and implementing the workplace violence prevention plans that can better address the variety of healthcare settings in which they will be implemented.

Thank you for the opportunity to review this first discussion draft. We look forward to continuing to participate in the advisory committee process and working with Cal/OSHA to develop regulations that support a safe workplace for physicians, their employees and patients.

Sincerely,

Yvonne Choong

Senior Director, Center for Medical and Regulatory Policy