Workplace Violence Prevention Programs in NJ Healthcare Facilities

Request for Office of Management and Budget Review and Approval for Federally Sponsored Data Collection
OMB Control # 0920-0914; expiration date 2/29/2016

Section A

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- Goal of the study – The proposed study is designed to: (1) to examine nursing homes compliance with the New Jersey (NJ) Violence Prevention in Health Care Facilities Act (2) to compare the assault injuries to nursing home workers, 3 years before the Act and 3 years after the Act, in New Jersey and in Virginia, which does not have such an act/regulation.
- Intended use of the resulting data - 1) publish the findings in a peer-reviewed scientific journal, and in industry and healthcare association journals, 2) disseminate the information to health departments for potential development of workplace violence prevention programs.
- Methods to be used to collect – in-person interviews with nursing home administrators. This study will use the percentage of nursing homes in NJ that have violence prevention programs in relation to that of a comparison state, Virginia as a surrogate for potential effectiveness.

A. Justification

A.1 Circumstances Making the Collection of Information Necessary

This is a revised Information Collection Request (ICR) from the National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention seeking a two year approval from OMB. The currently approved ICR (0920-0914; expiration date 2/29/2016) is for data collection at 50 hospitals for a 4000 nurse survey, 4000 home healthcare aide survey, and 20 nursing home interviews. Data collection is complete for the hospitals, nurse survey and home healthcare aide survey. We were unable to conduct the 20 nursing home interviews. Therefore, we are revising the existing ICR in order to complete the 20 nursing home interviews as well as add an additional 20 nursing homes based in Virginia as a comparison group (40 nursing homes total; 20 in Virginia and 20 in New Jersey). The currently approved ICR also contains a survey that collects nursing home injury data. We would like to drop this survey and instead collect publicly available workers compensation data.

Under the Public Law 91-596 (Section 20[a][1]), NIOSH is tasked with conducting research relating to occupational safety and health (Appendix A). The need for this information collection is described in this section. The workforce that provides nursing home healthcare is growing rapidly, with increases likely to continue with the aging population and changes in healthcare delivery policy. Nursing and residential care facilities reported 204,300 nonfatal injuries and illnesses in 2007 with a rate of 8.8 per 100 full-time workers which is the highest for the healthcare and social assistance sector.

Employee violence-related injuries are any physical assault, threatening behavior, or verbal abuse occurring in the work setting" *(NIOSH, DHHS (NIOSH) Publication Number 96-100, July 1996)*. For this study, employee violence-related injuries are perpetrated by nursing home residents towards nursing home employees. Workers' compensation claims tend to be filed for only the most severe injuries; we will not obtain minor injuries which is a limitation. Workers' compensation claims are coded but not specifically for violence. Therefore, we will review each claim narrative to capture the violence-related injuries. In New Jersey and Virginia, the workers' compensation program are administered and regulated at the state level. Both states require employers to report all claims that result in medical treatment beyond first aid. (Workers' Compensation Insurance: A Primer for Public Health, DHHS NIOSH Publication No. 2014-110).

The objective of the proposed study is: (1) to examine nursing homes compliance with the New Jersey (NJ) Violence Prevention in Health Care Facilities Act [dates of implementation as required by the NJ regulation are the following: the overall programs (policies, reporting systems, committee) 12/6/2014, violence prevention plan 3/6/2012, risk assessments 3/6/2012 annually, violence prevention training developed 6/6/2012], and (2) to compare the assault injuries to nursing home workers, 3 years before the Act and 3 years after the Act, in New Jersey and in Virginia, which does not have such a act/regulation. Our central hypothesis is that nursing home facilities under the NJ regulations will have more comprehensive workplace violence prevention programs than nursing homes not under the regulation (Virginia). This project compares the comprehensiveness of nursing home workplace violence prevention programs in New Jersey (NJ) with the comprehensiveness of programs in Virginia (VA). Virginia was selected as the comparison state for the following reasons: the distributions (size and type) of nursing homes is similar to NJ; the 2013 population estimates are similar; percent of persons 65 years and over are similar. Licensure is required for nursing homes in New Jersey and Virginia. The sampling frame of nursing homes eligible to participate in this study will include all nursing homes (n=362) licensed in NJ by the Department of Health and covered by the regulations and all nursing homes (n=279) licensed in VA by the Department of Health Professions. We will be comparing the percentage of NJ nursing homes who have violence prevention programs to the percentage of VA nursing homes who have violence prevention programs as a measure of the potential effectiveness of the NJ regulations.

New Jersey and Virginia info: In 2015, New Jersey had a population estimate of 8,938,175; 2010 resident census population 65 years and over of 13.5%; and median age of 39. In 2015, Virginia had a population estimate of 8,382,993; 2010 resident census population 65 years and over of 12.2%; and median age of 37.5. Characteristics related to nursing home in NJ: small 24%, medium 59%, and large 15%; for profit 69%, non-profit 25%, and government 6%. Characteristics related to nursing home in VA: small 43%, medium 52%, and large 5%; for profit 68%, non-profit 27%, and government 5%.

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Regulatory environment in New Jersey and Virginia: Dr. Blando surveyed regulations in Virginia and there are no regulations that overlap with the NJ regulations. In fact, there are no workplace violence prevention regulations of any kind in Virginia, including no regulations of any kind for workplace violence in nursing homes. Virginia is a state plan state (enforcement for the private sector and the state and local public sector), so they defer everything regarding workplace health to federal OSHA regulations that are enforced by state workers from the

VAOSH. They generally do not exceed any of the federal regulations for workplace health and safety. NJ is a state plan state with enforcement for the state and local public sector; OSHA provides enforcement of the private sector. The regulatory environment is different between the states of NJ and VA. In particular, VA is a "right to work" state and as such prohibits the requirement for any worker to belong to a union, even unions that do collective bargaining on behalf of all workers. As such, unions are very weak or non-existent in Virginia. By contrast, NJ has a long history of unions and collective bargaining. As such NJ tends to be more proactive and balanced with regard to worker protections and rights. This is evidenced by the fact that NJ has a workplace violence prevention in healthcare regulation, which was strongly supported and pushed by worker unions, and Virginia has no such regulation, where unions generally do not exist.

Characteristics related to nursing home patients in NJ and VA:

Table 3.1.b. Percentage of State Residents in a Nursing Home: United States, 2012 Percentage of State Residents in a Nursing Home

	Both Genders			Men			Women		
	All ages	65+	85+	All ages	65+	85+	All ages	65+	85+
New Jersey	0.5	3.2	11.0	0.4	2.3	7.3	0.7	3.9	12.8
Virginia	0.4	2.4	9.1	0.2	1.6	5.7	0.5	3.0	10.8

Table 3.5.b. Nursing Home Residents by Sex, Age Group and State: United States, 2012

		Gender		Percent by Age Group						
	# residents	Male	Female	**0-21**	**22-30**	**31-64**	**65-74**	**75-84**	**85-94**	**95+**
New Jersey	47,227	34.0	66.0	0.7	0.3	14.3	14.6	26.1	35.9	8.2
Virginia	29,309	32.0	68.0	0.3	0.3	13.9	16.1	28.3	34.3	6.9

Table 3.6.b. Nursing Home Residents by Race/Ethnicity and State: United States, 2012

		Percentage of Residents						
	# residents	**American Indian or Alaska Native**	**Asian**	**Black, not Hispanic origin**	**Hispanic or Latino**	**Native Hawaiian or Pacific Islander**	**White, not Hispanic origin**	**More than one Race**
New Jersey	47,227	0.1	2.1	16.7	7.0	0.2	73.6	0.3
Virginia	29,309	0.1	1.2	24.4	0.9	0.0	73.3	0.1

Table 3.7.b. Distribution of Activities of Daily Living Impairment (ADL) in Nursing Home Residents: United States, 2012

		Number of ADL Impairments – Percentage of Residents					
	# residents	**0**	**1**	**2**	**3**	**4**	**5**
New Jersey	47,227	18.3	6.0	5.6	6.6	40.4	23.2
Virginia	29,309	17.5	6.0	5.3	5.9	40.1	25.2

Table 3.8.b. Distribution of Cognitive Impairment in Nursing Home Residents: United States, 2012

		Cognitive Impairment - Percentage of Residents		
	# residents	**None to Mild**	**Moderate**	**Severe**
New Jersey	47,227	38.3	24.2	37.5
Virginia	29,309	37.1	24.5	38.4

Table 3.10.b. Distribution of Recent Falls in Nursing Home Residents: United States, 2012

		Falls - Percentage of Residents		
	# residents	**None**	**1+ Falls, No Injury**	**1+ Injurious Falls**
New Jersey	47,227	86.9	9.6	3.4
Virginia	29,309	83.1	12.0	5.0

Table 3.11.b. Clinical Characteristics of Nursing Home Residents by State: United States, 2012

	Percentage of Residents					
	Pressure Ulcers	**Restraints**	**Incontinence**	**Feeding Tube**	**Weight Loss**	**Antipsychotic Medication**
New Jersey	7.1	2.1	37.5	6.9	6.1	21.0
Virginia	5.8	0.8	41.8	5.9	6.7	23.1

Source: United States Department of Health and Human Services (2013). Nursing Home Data Compendium 2013 Edition, Centers for Medicare and Medicaid (CMS), Washington, DC.

Characteristics related to nursing home staff in NJ and VA:

	Staff hours per resident per day					
	CNA hours per resident per day	LPN hours per resident per day	RN hours per resident per day	Licensed staff hours per resident per day	Total nurse hours per resident per day	Physical Therapist hours per resident per day
New Jersey	2.28	0.77	1.04	1.81	4.1	0.17
Virginia	2.3	1.05	0.81	1.86	4.16	0.12

Source: Staff Data for nursing homes processed on 2/1/16 Via Center for Medicare and Medicaid Services (CMS). Available at: https://data.medicare.gov/data/nursing-home-compare

Limitations of the comparison: One, most of the information that will be collected through self-report, which could lead to reporting bias and the misclassification of the presence of workplace violence prevention program components. Two, differential response rates between New Jersey and Virginia could introduce a bias. Three, an assessment of the quality of the components will not be conducted. Limitations will be addressed in any publications or presentation.

Nine states have workplace violence prevention requirements for healthcare workers – California, Connecticut, Illinois, Maine, Maryland, New Jersey, New York, Oregon, and Washington. Please see table below on the Occupational Safety and Health (OS&H) specifics for each state (Workers' Compensation Insurance: A Primer for Public Health, DHHS NIOSH Publication No. 2014-110).

States with statutes, rules and/or regulations about employer-based occupational safety and health program elements plus states with approved state OSHA Plans or consultation programs only, 2011

State OS&H Regulations	States
Requirements	
Employer Written Safety and Health Program	CA1, HI2, LA3, MN4, NE, NV5, NH5, NC6,WA
Employer/Employee Safety and Health Committee	AL7, CA4, CT8, MN9, MT10, NE, NV11, NH10, NC12, OR13, TN14, WA5
Insurer to Provide Loss Prevention Services	AR, CA, KS, MS, MO, MT, NM, OR, PA, RI, SD, TX
On-Site Inspection by Loss Prevention Services	AR15, CA16, DE17, NM18, NY19, RI20, TX21
Incentives	
Premium Reduction for Safety Program Elements	CO, DE22, FL, HI, ME, NH, NM, NY, ND, OH, OK, PA, SD23, UT24, WI, WY25
Employer Penalty for Violation of Rule at Time of Injury	CA, IL, MA, MO, NC, WI
Safety Grant	MA26, MN, NY, ND, OH, OR26,UT, WA
Registry of S&H Practitioners	HI, LA, MO
State OSHA Plan	AK, AZ, CA, CT27, HI, IL27, IN, IA, KY, MD, MI, MN, NV, NJ27, NM, NY27, NC, OR, SC, TN, UT, VT, VA, WA, WY

State Consultation Program Only	AL, AR, CO, DE, FL, GA, ID, KS, LA, ME, MA, MS, MO, MT, NE, NH, ND, OH, OK, PA, RI, SD, TX, WV, WI

A.2 Purpose and Use of Information Collection

The Violence Prevention Committee is responsible for completion of an annual violence risk assessment to analyze risk factors for workplace violence and to identify patterns of violence; and development of a written violence prevention plan that shall be submitted to facility administration.

The purpose of the interviews with the nursing home administrators is to measure compliance to the state regulations for a workplace violence prevention program: violence prevention policies, reporting systems for violent events, violence prevention committee, written violence prevention plan, violence risk assessments, post incident response and violence prevention training (objective 1; utilize the Abstraction Form and the Committee Chair Interview form). We will utilize the Abstraction Form (Appendix C1) to collect data on the specifics of each component of their workplace violence prevention program. Positive need for this data is the collection of nursing home workplace violence prevention program components which have never been collected before; this information can be utilized by NJ state legislature. We will utilize the Committee Chair Interview (Appendix C2) to collect data on the nursing home's policies and procedures for workplace violence prevention, their security services and barriers to developing and implementing the work workplace violence prevention program. The positive need for this collection is that the information can be disseminated to nursing homes regarding implementation of a workplace violence prevention program. A negative consequence of not obtaining this information from appendices C1 and C2 is that nursing homes will not have valuable tools to assist in implementing a workplace violence prevention program. Another negative consequence of not having the compliance information is that a high number of injuries will continue to occur to healthcare workers because NIOSH in accordance with its mandate did not move to disseminate successful legislation results to communities, to health departments, and to legislative bodies. Pre-act data will not be collected.

Workers' compensation claims (violence-related injuries) will be utilized for Objective 2, to compare the assault injuries to nursing home workers, 3 years before the Act and 3 years after the Act, in New Jersey and in Virginia, which does not have such an act/regulation. Three years prior to the legislation (2009-2011) and three years post-legislation (2012-2014) will be collected.

The purpose of the information collected is to disseminate the information to NJ state health departments for potential development of state legislation for a workplace violence prevention programs. Barriers and facilitators to implementing a workplace violence prevention program will be distributed to nursing homes in NJ.

A.3 Use of Improved Information Technology and Burden Reduction

The personal interview methodology (using Appendices C1 and C2) was employed because this worked in the previous hospital NIOSH study. The 20 nursing homes will provide a comparison group; compare New Jersey (regulated state) compliance proportions to Virginia (nonregulated state) compliance proportions. To minimize the time of nursing home workers collecting the data, we will not use electronic respondent reporting. Therefore, we will use appendices C1 and C2 to conduct an interview with the nursing home administrators.

A.4 Efforts to Identify Duplication and Use of Similar Information

Only one study (see reference below) has examined compliance to legislation mandating implementation of comprehensive workplace violence prevention programs in healthcare facilities for reducing violence to workers. The NIOSH-funded work examined a similar measure of potential effectiveness, looking at assault rates in California after its law was put into place, as compared to NJ hospitals (who at that time did not have a law in place). In this work, they found that assault rates to emergency department and psychiatric unit workers in California (with the law in place) were lower compared to assault rates in NJ hospitals. They also found that California hospitals had implemented many of the elements of a comprehensive violence prevention program. However, the California evaluation was unable to measure how the comprehensiveness of hospital workplace violence prevention programs changed as a result of the California law because they were unable to describe hospital programs prior to enactment of the law. The findings from our study will have useful policy implications for New Jersey and for other states looking to enact workplace prevention laws.

Reference: Workplace violence prevention programs in hospital emergency departments. Peek-Asa C, Casteel C, Allareddy V, Nocera M, Goldmacher S, OHagan E, Blando J, Valiante D, Gillen M, Harrison R. Journal of Occupational and Environmental Medicine. 2007 Jul; 49(7):756-63.

A.5 Impact on Small Businesses or Other Small Entities

Small business may be involved in the data collection. Questions have been held to the absolute minimum required for the intended use of the data/information. We will not be collecting nursing home assault injury data since this is very time intensive. Therefore, we will be collecting publicly available workers compensation data.

A.6 Consequences of Collecting the Information Less Frequently

The information request is for a one-time collection only. There are no technical or legal obstacles to reduce the burden.

A.7 Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances connected with the information collection.

A.8 Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A. A 60-day Federal Register Notice was published in the *Federal Register* on March 27, 2015, vol. 77, No. 148, pp. 45617-45618 (see Appendix B). We received no comments.

B. We consulted outside the agency with the University of North Carolina, and Old Dominion University.

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A.9 Explanation of Any Payment or Gift to Respondents

The information collection does not provide a payment or gift to the respondents.

A.10 Protection of the Privacy and Confidentiality of Information Provided by Respondents

Privacy Impact Assessment Information

This submission has been reviewed by CDC's Information Collection Review Office (ICRO), who determined that the Privacy Act does not apply.

Facility (nursing home) interview

Interviews with Violence Prevention Committee Chairs: The purpose of these interviews with the nursing home chairs of the Violence Prevention Committees is to measure compliance to the state regulations (violence prevention policies, violence prevention committee, written violence prevention plan, violence risk assessments, post incident response and violence prevention training). Appendices C1 and C2 will be utilized during the interview.

Facility (Nursing Home) Interview (Appendix D): The letter of introduction and fact sheet will be sent to the Chair of the Violence Prevention committee introducing the study and the benefits of participation by Dr. Blando. Verbal consent from the Chair of the Violence Prevention committee to participate will be obtained by Dr. Blando. The information to be collected, the intended uses of the data, the minimal risk connected with their participation, and who to contact in the event of liability will be explained to them by Dr. Blando.

Respondents will be informed that their participation in providing information is voluntary. The Privacy Act does not apply as no personally identifiable information is collected, however intended use of the data and the minimal risk in participation will be explained to them. There will be no effect on the Chairs of the Violence Prevention committee who refuse to participate and do not reply to the information request.

A.11 Institutional Review Board (IRB) and Justification for Sensitive Questions

The protocol was approved by the IRB (Appendix E).

There will be no questions of a sensitive nature added to any of the data collection forms.

A.12 Estimates of Annualized Burden Hours and Costs

We are revising our existing ICR to include an additional 20 nursing homes (40 nursing homes total). The table below shows the annualized burden hours. There are 20 respondents (nursing home administrators) that will be interviewed each year. This will include 10 respondents from Virginia and 10 respondents from New Jersey. The abstraction form and the committee chair interview (appendices C1 and C2) will be used during the interview. Each form will take approximately 1 hour which results in 20 burden hours each. The total burden hours is 40.

The requested change will not change the scope of the study. This collection will expand over 2 years. The total burden hours will increase by 19 hours.

Estimated annualized Burden Hours

Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hrs)	Total Burden (in hrs)
Nursing Home Administrators	Evaluation of Nursing Home Workplace Violence Prevention Program: Abstraction	20	1	1	20

	Form				
Nursing Home Administrators	Committee Chair Interview	20	1	1	20
Total					40

An estimate of the annualized burden costs is provided below using Bureau of Labor Statistics (BLS) estimate wages by occupation.

The total cost will increase by $1289.

Estimates of Annualized Burden Costs

Type of Respondent*	**Total Burden Hours**	**Hourly Wage Rate**	**Total Respondent Costs**
Nursing Home Administrators	40	41.22	$1648
Total			$1648

* These estimates are calculated using the U.S. Department of Labor's National Occupational Employment and Wage Estimates for the United States. May, 2014. (http://www.bls.gov/oes/current/oes119111.htm). Salaries for nursing home administrators were estimated to be that of the BLS category of management occupations (medical and health services managers). The total annualized burden costs are $1648.

A.13 Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

There are no additional cost burdens for respondents.

A.14 Annualized Cost to the Government

The annualized cost to the government for this project is estimated to be $19612. The table below summarizes a breakdown of the estimated costs.

Item	**FY 2016**	**FY2017**	**Total**
Discretionary costs: Equipment and supplies[1]			0
Contractual	$19612	$19612	$39224
Travel			0
Total Discretionary	$19612	$19612	$29224
Total Personnel and benefits			$0
Total cost to Federal Government	$19612	$19612	$39224

FY16 $19612
FY 17$19612
FY18 No cost extension for the contract

A.15 Explanation for Program Changes or Adjustments

We received OMB approval (0920-0914) to evaluate the legislation at 50 hospitals and at 20 nursing homes, to conduct a nurse survey and to conduct a home healthcare aide survey. Data collection is complete for the hospitals, the nurse survey, and the home healthcare aide survey. We were unable to conduct the 20 nursing home interviews due to a lack of budget. We obtained funding in March 2015 to conduct 40 nursing home interviews so we are requesting a revision to evaluate the legislation at an additional 20 nursing homes. Twenty nursing home interviews will be conducted in Virginia and 20 nursing home interviews will be conducted in New Jersey. This addition results in an increase in the number of responses and burden hours.

We will not be collecting nursing home injury data (not using Nursing Home Administrator C3 Employee Incident Information form) since this is very time intensive. There is also not a standard reporting system with standard workplace violence definitions for nursing homes to utilize.

Nursing homes (with 10 or more employees) are required to file workers compensation data for work-related injuries and illnesses that result in death, loss of consciousness, days away from work, restricted work activity or job transfer, or medical treatment beyond first aid. Therefore we will collect workers compensation data for New Jersey and Virginia for 2009-2014 The purpose of collecting this data is to evaluate changes in assault injury rates before and after enactment of the regulations. Data for the denominators of the rates will be the number of workers compensation claims per nursing home per state per year. Personal identifiers of employees or perpetrators will not be collected. A previous study (see reference below) has shown the feasibility of calculating rates of worker's compensation claims by nurses employed in nursing homes.

Staffing and Worker Injury in Nursing Homes. Trinkoff AM, Johantgen M, Muntaner C, and Rong L. American Journal of Public Health. July 2005, 95 (7): 1220-1225.

A.16 Plans for Tabulation and Publication and Project Time Schedule

After the revision request is approved, data collection will begin for the 20 nursing homes in the first year and 20 nursing homes in second year. Clearance is being requested for 24 months, starting in February, 2016 and continuing through February 2018.

We plan to publish project results in peer reviewed scientific journals with a high impact number. Limitations of the collection (reporting bias, misclassification, differential response rates, no assessment of quality of component) will be communicated in any publications or presentations. Additionally, results will be presented at national, scientific conferences with high public visibility to research audiences, and at trade associations in order to reach both industry and community leaders that are empowered to promulgate legislative ordinances for healthcare worker safety. Results will also be disseminated to stakeholder groups via presentation and written reports.

Activity	Time Schedule
Draw final sample from sampling frame 1 month after OMB approval	1 month after OMB approval
Begin interviews with Chair of Workplace Violence Prevention committee	2 months after OMB approval
Complete interviews	12-24 months after OMB approval
Complete cleaning of data and database development	24-26 months after OMB approval
Complete statistical analysis	27-30 months after OMB approval
Complete papers and reports for publication in peer-review journals & trade association journals & publications.	30-36 months after OMB approval
Complete presentations to research audiences and stakeholders	30-36 months after OMB approval

A.17 Reason(s) Display of OMB Expiration Date is Inappropriate

The OMB expiration date will be displayed on all questionnaires (Interview form, and Nursing Home Abstraction form).

A.18 Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.