

That is why I am a proud cosponsor of H.R. 4995, the Maternal Health Quality Improvement Act. This legislation would create rural maternal network grant programs and ensure maternal health providers are eligible for telehealth.

This is especially impactful for Granite State families that face long distances and deal with extreme workforce shortages that make it difficult to access much-needed care. For them, having access to telehealth for maternal care is a real life-changer.

We must all continue to support and lift up the innovation, quality, and service of rural healthcare providers and facilities.

RECOGNIZING PULMONARY HYPERTENSION AWARENESS MONTH AND NATIONAL ADOPTION MONTH

(Mr. BRADY asked and was given permission to address the House for 1 minute.)

Mr. BRADY. Madam Speaker, I rise today in recognition of two important events in November: Pulmonary Hypertension Awareness Month and National Adoption Month.

Pulmonary hypertension was first brought to my attention by my dear friend Jack Stibbs, whose daughter, Emily, had PH. Because of her early diagnosis and his terrific leadership, Emily has been able to lead a relatively normal life and recently graduated from college and married. However, not all patients are as fortunate as she.

That is why the work of the Pulmonary Hypertension Association is so important. Their efforts to increase awareness and research across Federal agencies are making a huge difference in lives across the Nation. I am proud to represent the PHA Lone Star Chapter in The Woodlands, Texas.

November is also National Adoption Month. This is a cause I hold close to my heart because it is thanks to the miracle of adoption that I have my incredible family today.

During this month, we recognize and thank the adoptive parents, dedicated professionals, and the faith-based organizations that work tirelessly to provide our Nation's children with love and support.

Madam Speaker, I ask my colleagues to join me in raising awareness and saying thanks to these two great causes.

WORKPLACE VIOLENCE PREVENTION FOR HEALTH CARE AND SOCIAL SERVICE WORKERS ACT

GENERAL LEAVE

Mr. COURTNEY. Madam Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous materials on H.R. 1309.

The SPEAKER pro tempore (Ms. BROWNLEY of California). Is there ob-

jection to the request of the gentleman from Connecticut?

There was no objection.

The SPEAKER pro tempore. Pursuant to House Resolution 713 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the state of the Union for the consideration of the bill, H.R. 1309.

The Chair appoints the gentlewoman from Texas (Ms. JACKSON LEE) to preside over the Committee of the Whole.

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IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the state of the Union for the consideration of the bill (H.R. 1309) to direct the Secretary of Labor to issue an occupational safety and health standard that requires covered employers within the health care and social service industries to develop and implement a comprehensive workplace violence prevention plan, and for other purposes, with Ms. JACKSON LEE in the chair.

The Clerk read the title of the bill.

The CHAIR. Pursuant to the rule, the bill is considered read the first time.

General debate shall be confined to the bill and shall not exceed 1 hour equally divided and controlled by the Chair and ranking minority member of the Committee on Education and Labor.

The gentleman from Connecticut (Mr. COURTNEY) and the gentlewoman from North Carolina (Ms. FOXX) each will control 30 minutes.

The Chair recognizes the gentleman from Connecticut.

Mr. COURTNEY. Madam Chair, I yield myself such time as I may consume.

Madam Chair, today's vote on H.R. 1309 is an important milestone in what has been a 7-year process of getting the Occupational Safety and Health Administration to effectively act to protect the healthcare and social service workforce from skyrocketing rates of violence.

Sadly, in America today, nurses, doctors, social workers, EMTs, and nursing assistants are more likely to be the victim of on-the-job violence than any other sector of our Nation's workforce.

This violence comes in the form of assaults, kicking, hitting, choking, and spitting from patients and residents and clients or those who may accompany them. It affects a worker's sense of safety at work. It contributes to burnout, absenteeism, high workers' compensation costs, and stress. Tragically, it can also lead to death.

According to the Bureau of Labor Statistics, healthcare and social service workers are more than five times as likely to suffer a serious injury from workplace violence than workers in other settings. And this chart, which shows the red line of healthcare workers versus other sectors in the U.S. economy vividly, powerfully demonstrates the data that is coming into the Department of Labor on this issue.

In psychiatric hospitals, that number is drastically higher. In a recent survey, nearly 50 percent of emergency room physicians report having been physically assaulted at work, and 60 percent of those who have these occurrences said they happened in the past year.

As this graph shows, these numbers are on the rise. The incidents of violence in the workplace have increased 80 percent over the last decade.

Since OSHA has not effectively addressed this emergency, this bill is necessary to ensure that a standard is issued and enforced in a reasonable period of time.

Using past precedent, the bill calls for an interim final standard within 1 year and a final standard within 42 months. The public comment and rule-making process is preserved in the development of the final standard.

Very simply, the standard required by the bill would require that covered employers, such as hospitals and psychiatric facilities, develop a workplace violence prevention plan that is tailored to the specific conditions and hazards present at each workplace. It is not a one-size-fits-all requirement.

Madam Chair, developing a plan is not rocket science. For over 20 years, OSHA has published voluntary guidelines on violence prevention that include commonsense measures, such as training staff about how to identify high-risk patients, share the information with coworkers, not be alone, and ways to de-escalate threats. We know from the Joint Commission on Hospital Accreditation that these measures work, and the problem is, though, that there is no consistent enforceable standard to ensure their application, and that is precisely what this bill does.

While we will never eliminate all risk or stop every violent attack, research on the measures in this legislation have been shown to substantially cut the incidence of serious injury from workplace violence. The nurses, doctors, social workers, and EMTs who care for us in our times of crisis and need deserve to have these protections soon, not in 7 years and not in 20 years, as is likely if we fail to pass this legislation into law, leaving OSHA rule-making to its own dilatory, almost comatose, devices.

I would like to thank the large coalition of healthcare professionals, their organizations, and union representation who have diligently fought for these protections for years; the subcommittee chair, ALMA ADAMS, of the Workforce Subcommittee on Education and Labor and Chairman BOBBY SCOTT for their leadership; also, Richard Miller and Jordan Barab, our committee staff, who have done amazing work, as well as Maria Costigan from my personal office, who have just worked night and day for years to try and get us to this point.

Madam Chair, I reserve the balance of my time.