SB 537 Workplace Violence Prevention Safety Requirements in Healthcare Settings Rule Advisory Committee
October 10, 2025
9 a.m. via Microsoft Teams

RAC MEMBER ATTENDEES	
Alicia Holihan	Peace Health
Barb Hansen	Oregon Hospice and Palliative Care Assoc
Ben Gurewitz	Disability Rights Oregon
Bill Schueler	Oregon Emergency Nurses Association
Brian Boggess	Samaritan Health Services
Christie Wiles	Sky Lakes Medical Center
C. Craig Rudy	Oregon Chapter, ACEP
Emily Bennett	Providence Home & Community Care
Emily Cronan	Oregon Nurses Association
Hollie Caldwell	Oregon Center for Nursing
Iria Nishimura	Willamette Vital Health
Jamie Daugherty	Oregon Association for Home Care
Jamie Harbick	Registered Nurse
Janna Higgins	OHSU
Jennifer Thornburgh	Kaiser Permanente
Karen Reed	Harney District Hospital
Katie Harris	Hospital Association of Oregon
Libby Batlan	Oregon Health Care Association
Lynda Enos	HumanFit LLC
Mark Bonanno	Oregon Medical Association
Mark Sohm	Legacy Health
Mary Avalon	Multnomah County BHAC
Matt Swanson	SEIU
Matt Clark	Samaritan Evergreen Hospice
Michelle Brenholdt	Registered Nurse
Odalis Aguilar	Oregon AFSCME
Travis Nelson	Oregon Legislature
Tyler Kerns	Saint Alphonsus Health System
Wendy Hasson	Oregon Pediatric Society
Wendy Trapp	Providence

OTHER INTERESTED PARTY ATTENDEES	
AlGene Caraulia	Crisis Prevention Institute
AmyBeth Altenhofen	Chief of Staff-Rep. Nelson
Angela Eastman	Asante
Bridget Mangan	Crisis Prevention Institute
David Jacobson	Asante
Jackie Fabrick	Providence
Jesse Cornett	Kaiser Permanente
Julie Baker	Morrow County Health District
Michael Dzick	Crisis Prevention Institute
Olivia Mannon	OHSU
Paige Spence	Oregon Nurses Association
Tracy Douglas	Crisis Prevention Institute
OHA and State Partners	
Anna Davis	Public Health Division (PHD), Health Care Regulation and Quality Improvement (HCRQI)
Dana Selover	PHD-HCRQI
Gretchen Hall-Wunderlich	Dept of Consumer and Business Services (DCBS) - Oregon OSHA
Gretchen Koch	Oregon State Board of Nursing (OSBN)
Jennifer Stewart	DCBS-Oregon OSHA
Jerry Walker	PHD-HCRQI
Linda Presnell	DCBS-Oregon OSHA
Mellony Bernal	PHD-HCRQI
Sadie Morrissey	PHD HCRQI

Welcome and Meeting Procedures

Mellony Bernal welcomed RAC members and introduced the meeting and went over meeting procedures and expectations.

- It was noted that the meeting is being recorded and all information shared is a matter of public record and may be disclosed.
- Per OHA policy, members of the public may observe only. Should public members have information they would like to share, they can send information by email to mellony.c.bernal@oha.oregon.gov or to sadie.morrissey@oha.oregon.gov. Any information received will be shared with RAC members and OHA staff.
- Microsoft Teams features such as the Chat and Raise Hand features were reviewed and instructions on how to communicate during the RAC were shared.
- Information about the Health Facility Licensing and Certification (HFLC) program's rulemaking activity website was shared including where people can find information about new and amended rules, temporary rules, proposed rules, and other relevant information.

Roll call was taken and RAC members introduced themselves.

Overview

Dana Selover provided an overview of the rulemaking process explaining the steps involved, including the drafting process, RAC membership selection, convening rulemaking advisory committees (RACs), submitting rules to the Secretary of State's Office, holding a public hearing, responding to public comment, and finalizing rules. The importance of the public comment process and the role of the Rule Advisory Committee was noted. If a RAC member cannot attend a meeting and they would like someone to attend in their place, the RAC member must email mellony.c.bernal@oha.oregon.gov to identify who will be attending.

D. Selover reviewed the scope of the rulemaking with the focus primarily on SB 537 and requirements for Home Health Agencies and Hospice Programs. These requirements cover patient intake processes, training, and workplace violence prevention programs. Additionally, minor changes including statutory updates and removal of outdated language are proposed. Waivers for equity and geographic service areas is proposed as well as confidentiality provisions to align with statute.

Two additional meetings have been scheduled for October 24 and November 3.

Proposed deadline dates were shared in order to have permanent rules in place by January 15, 2026.

Rule Summary and SB 537 Overview

D. Selover noted that rules will not be reviewed chronologically, rather rules changed as a result of SB 537 will be reviewed first. Four sets of rules are being amended based on facility type and will cover definitions, policies, personnel, workplace violence programs, flagging systems, and clinical records. These rules include:

- 333-027 – Home Health Agencies
- 333-035 – Hospice Programs
- 333-071 – Special Inpatient Care Facilities
- 333-500, 505, 535 – Hospitals

A table summarizing the elements of SB 537 was shared and it was noted which sections would be the responsibility of Oregon OSHA and those that the Public Health Division (PHD) will be responsible for. The table further identifies which sections impact facility types. The PHD proposed rules will address the following:

- Section 8 – ID badge requirements for hospitals (minor modification to rule)
- Section 9 – Protocols and procedures for visual and electronic flagging systems
- Section 10 & 11 – Bullet resistant barriers or enclosures
- Section 12 – Client intake process
- Section 13 – Training requirements

Section 3 of SB 537 includes training requirements that will be overseen by Oregon OSHA. Linda Presnell from Oregon OSHA explained that the agency will convene a Rule Advisory Group to support this effort, and any interested person may attend. It was noted that OSHA is still reviewing the language in the bill to determine its specific responsibilities. The following link was provided, where updates and additional information will be posted: https://osha.oregon.gov/rules/advisory/healthcare-employee-safety/Pages/default.aspx. It is anticipated that the advisory group will be convened before the end of the year.

A RAC member asked about the definition of workplace violence which is the foundation for considering proposed rules. The definition from the bill was posted in the Chat: *"Workplace violence" includes any act or threat of physical violence, harassment, intimidation, assault, homicide or any other threatening behavior that occurs in the workplace*.

Via Chat, RAC member stated that consistent rules between OSHA and PHD are needed and rules should be adopted congruently to alleviate administrative burden by trying to follow two different sets of rules.

OAR 333-027-0005 – Definitions

The definitions section has been added for reference purposes. Currently there are no changes proposed to definitions. If additional definitions are needed based on discussions, definitions could be added here or the specific rule where the term is used.

OAR 333-027-0060 – Administration of Home Health Agency

This rule has been modified to clarify that a Home Health Agency (HHA) must have a personnel policy on the completion of worker safety training in accordance with OAR 333-027-0115, which must be reviewed by the HHA's professional policy-making committee on an annual basis. Additionally, the rule adds that personnel records must document the completion of worker safety training.

There were no comments from RAC members.

OAR 333-027-0115 – Worker Safety Program Requirements

D. Selover noted that this new rule is proposed to address the requirements of SB 537, section 12 (client intake assessment) and section 13 (training). She requested feedback from both HHAs and Hospice Programs as the Hospice Program rule is similarly aligned.

Discussion:

Section (1) – Risk Assessment

- RAC member expressed concern with current language regarding weapons and noted that the requirement in the bill is not to identify the presence of weapons in the home, rather that the patient agrees that if they have weapons, they will be locked up, secured, and out of sight during a home visit.
    - Via Chat, there should be a second step if the client refuses to lock weapons. Can admission be discontinued at that time? Can authorities be contacted?
- RAC member expressed concern that a person expressing violence is often a caretaker and cannot be removed from the patient. Information on the caretaker should be relayed to HHAs and Hospice since there is a risk of violence but not related to the patient. The rules do not address history of a caretaker or other individuals and staff should consider adding a reference to the caregiver as well for obtaining possible risk information. Discussion:
    - It was noted that early versions of the bill included obtaining history on other household individuals. HCRQI will assess statutory authority and whether it's feasible to add to rule.
    - Adult caregivers are frequently not family members and change frequently (neighbor, etc.) Potential administrative burden when considering identifying information on adults.
    - Considering removing the term "patient" from the header "patient intake risk assessment" altogether so it may apply to both patients and caregivers or other persons. It was noted that the risk assessment is in place to protect the health care workers from possible violence. It's also an assessment of the safety of the environment including persons in that environment who are excluded from the assessment.
    - RAC member requested that hazards be included in the patient risk assessment. Via Chat, is there an opportunity to add “hazard” to definitions that includes caregivers, visitors to home and household members? Could hazard be included to the Patient intake risk assessment in addition to the quarterly safety assessments?
    - Via Chat:
        - Hospice care is provided to a patient and the family/caregiver unit, always. Pediatric viewpoint as well as entire family issues of safety awareness is vital to assess.

        - Information about caregiver or family member aggression can and should be tracked but this can be left to organizational policies and procedures without being written into the rules specifically.
    - Wondering if we can adopt a benchmark definition of hazards from the Alliance, AHRQ and or CoPs specifically for HH&H settings.
    - RAC member via Chat noted, it does seem that there are many instances where SB 537 acknowledges threats from non-patient people in the environment such as parents/caregivers and would like to see environment- based language vs patient based when possible.

        Examples of acknowledgement of non-patient threats in SB 537

        SECTION 7

        654.416. (1) A health care employer shall maintain a record of assaults committed against employees that occur on the premises of the health care employer or in the home of a patient receiving home health care services. The record shall include, but need not be limited to, the following: (d) A description of the person who committed the assault as a patient, visitor, employee or other category;

        SECTION 9(1) As used in this section: (f) “Flagging system” means a system used to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals who may encounter health care providers and staff.

        SECTION 12(1) As used in this section and section 13 of this 2025 Act: (2) As part of any client intake process, a home health care services entity shall: (a) Collect information necessary to identify and assess potential health and safety related risks, including workplace violence as defined in ORS 654.412, that home health care staff may encounter while providing home health care services in home health care settings;

Section (2) – Hospital Discharge Coordination

- Concerns were expressed that information received from the hospital is missing information. The hospital regulations should also require that the hospital identify in records any violence during the patient's hospital stay or previous violence history, perhaps in the hospital rules relating to discharge. Discussion:
    - Development of clear policies and processes between the hospital and HHAs and Hospice Programs.
    - Via Chat:
        - Due to intent of the bill to coordinate care across settings as it relates to violence, hospitals would align information sharing to meet minimum requirements of the agency receiving the discharge.

        - The reverse is also applicable - home health should be able to provide hospital about history of violence, etc.
        - From what I'm aware of, the only information sharing system that communicates between hospitals/health systems is the EDIE (Emergency Department Information Exchange). But this system is not currently used to communicate risk for violence, rather, it communicates care planning. Link provided: https://ohlc.org/partner-initiatives/hit-commons/hit-commons-users-advisory-group/edie-utility/
    - What is any "known history of violence" especially as it relates to new flagging system requirements? How long to keep a flag if previous history of violence but nothing current? What about no history of violence at hospital but previous history externally? Consider that flagging systems in an electronic health record may not be part of the clinical record and how that translates to what may get put on discharge paperwork for HHA and Hospice.
        - HHAs, Hospice, and hospitals could collaborate to design a form or template on best practice for discharge information and what should be communicated from the hospital to the HHA or Hospice.
        - Information received is frequently prefabricated from the electronic medical records (EMR), and new form could perhaps be added to EPIC.
        - RAC member shared there is not a lot of consistency in the way violent episodes are documented within EPIC and hospital should work to align on this documentation. It's important to differentiate types of violent episodes (short term versus underlying risk.) Example shared of an episodic violence event that was resolved, but HH/Hospice environment was denied because of risk.
    - Via Chat, any known history can be helpful information to pass along. In terms of having a flag (communication tool) - procedures/policies should address auditing and when a flag could/should be removed or deactivated.
        - Via Chat, defining the context for violence and a patient's trigger(s) for violence is essential.
        - Via Chat, the statute does not prescribe the specific criteria for flagging. We should only call out that we need to have a policy and system in place for flagging and meet the statute as written. We cannot capture all of the nuances for patient's risk for violence in this document and should rely on health systems to formulate a plan/policy based on the rule making. I agree it's very important to have a process for visual and virtual flagging criteria as it's essential to protecting our workers, however, we should not be too prescriptive in statute.
- Consider whether there are ICD 10 codes that relate to violence or criminal history that could be added to the EMR.
    - Via Chat: The ICD-10 code for "violent behavior" is R45.6, which falls under the R40-R46 category for "Symptoms and signs involving cognition, perception,

emotional state and behavior". This is not always a billable code, but could be utilized to standardize communication.

- RAC member suggested that additional clarification be added such as "recent history of violence" or "history of violence within last 5 years." Patients should not be treated differently for events that happened 10 years ago.
    - RAC member suggested that there be a limit on how long a flag can be on a record. If a person continues to be safety risk the flag could be readded.

Section (4) – Training

- RAC member requested clarification on whether the training program established by an agency must be endorsed by both NIOSH and OSHA and if so, what does endorsement means. Discussion:
    - Use of interpretive guidance;
    - Adoption of specific guidance either in rule or by the facilities policy;
    - RAC member suggested to revise 333-027-0115(4) as follows removing the "," after home health care workers and after OSHA: "The training must be consistent with training for home health workers endorsed by NIOSH and OSHA and must include…" This will allow more flexibility while maintaining intent. The training program must be consistent with other training programs that have been endorsed by these federal bodies.
    - RAC member asked that "recognizing hazards" be further clarified or defined. Perhaps provide a list "including but not limited to…."
    - There is an overall deficit on workplace violence prevention training for all health care environments. NIOSH is a 10 year old training that is still posted, whereas, other trainings have been removed (i.e. OSHA). There is a need for up-to-date training that's freely available.
        - Via Chat, Effective WPV training should be customized to the care environment and specific risks for violence and prevention activities by the employer, etc.
    - Via Chat, it would be very helpful if the state of Oregon developed a current and evidence-based course similar to what has been done for pain management in Oregon.
    - Via Chat, I want to call out the opportunity we have to reframe the perspective around sharing context of violence. It should be viewed as objective as a way to prepare staff to care for the individual. Similar to infection control/PPE precautions. For example: a hx of violent behavior when being woken up in middle of night or high stimulus environment benefits both the clinician and the patient for more personalized care.

Section (5) – Quarterly Safety Assessment

- RAC member asked what would be included in the quarterly safety assessments? Would it be a quarterly survey? Review caseload with staff to ensure the safety? How would agencies capture a safety assessment with field staff?
    - Staff suggested it could be part of the Quality Assessment and Performance Improvement (QAPI) process and could include caseload assessment and incident review. Identifying challenges and incidents. What worked, didn't work. What could be done better.
    - Staff asked for suggestions from RAC members about what they think should be in a quarterly safety assessment.
    - RAC member suggested that it be further defined, for example, any kind of safety issues that have occurred during the quarter, including trainings that have occurred.
    - RAC member suggested that the rules further describe what are the minimum standards of a safety assessment, not necessarily just reviewing cases, but really identifying continuous improvement opportunities, similar to a QAPI plan.
- RAC member requested that hazards be included into the patient risk assessment.

Section (7) – Safety Checks

- RAC member asked for further clarification about safety checks and whether additional external applications are necessary especially for small hospice programs in rural Oregon. RAC member noted that in many areas of rural Oregon there is no signal to use electronics.
- SB 537, Section 13, subsection 4 requires an agency to provide mechanisms by which home health care staff can perform safety checks, including but not limited to the use of a mobile application to access the relevant safety-related information collected by the home health care services entity
- RAC member noted that it is important to know where workers are and is difficult when there is no cell signal. Example shared of locator beacons. It was suggested that additional information, such as requiring workers to check in at end of shift, be considered.
- Via Chat, the phrase "but not limited to" is important so that we're not forced into use of a mobile app.

Section (8) – Policy Development

- RAC member requested that additional information be added to mitigate unconscious bias to ensure that flagging is not disproportionately placed on persons of color. Staff encouraged RAC members to share possible language to add to rule regarding this.
- RAC member remarked that they would like the RAC to err on the side of giving as much information as possible to healthcare workers, because protecting them is a way of protecting patients.

ACTION ITEMS

OAR 333-027-0115

Section (1): Patient intake risk assessment

- Review statutory authority to collect information on caregivers or other individuals to assess risk to health care workers.
- Amend language regarding the presence of weapons in the home to align with the bill.
- Provide a clear definition of "hazards" in the context of the rules and specify what hazards staff should recognize.

Section (2): Hospital discharge coordination

- Consider defining 'known history of violence' or adding a term limit for individuals with a history of violence, such as within the past five years.
    - Review and potentially revise the wording in the rules to ensure hospitals are responsible for providing information regarding violence incidents during hospital stays or known previous violent history to the extent allowed.
    - HHAs and hospitals could collaborate to design a form or template on issues that should be communicated from the hospital to the HHA or Hospice. This is something that would not need to be incorporated into rule.
    - RAC member indicated that hospital flagging systems and electronic health records may be in separate systems and should be considered as requirements when rules are discussed.

Section (4): Training

- Edit rule removing the commas as suggested to allow for more flexibility (would not require that a training be endorsed by NIOSH/OSHA rather be consistent with).
- Consider whether "must be consistent with" may be interpreted through guidance instead of addressed by administrative rule.
- Determine whether training programs must be consistent with both NIOSH and OSHA.
- Define or clarify recognition of hazards and consider providing a list.

Section (5): Quarterly Safety Assessments

- Define minimum standards that should be included in the quarterly safety assessments for HHAs and Hospice.
- Consider elements to add to a list of “including but not limited to…”
- Add recognition of hazards to safety assessment.

Section (7): Safety Checks Mechanism

- Clarify the requirements for safety checks, including whether a mobile application is required and how to handle areas with no signal: satellite texting options, knowing where your staff are in remote areas, emergency protocols, etc.

Section (8): Policy Development

- Develop a policy to mitigate unconscious bias in the flagging system to ensure it does not disproportionately affect people of color.

Flagging System Criteria: Develop criteria for flagging systems that identify, communicate, monitor, and manage potential threats of violence or disruptive behavior.

NEXT STEPS
RAC members were encouraged to submit additional feedback and suggested rule language based on discussion. M. Bernal will forward calendar invitation for October 24 meeting including Teams meeting link.