SB 537 Workplace Violence Prevention Safety Requirements in Healthcare Settings Rule Advisory Committee
October 24, 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
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	
AmyBeth Altenhofen	Chief of Staff-Rep. Nelson
Angela Eastman	Asante
Jackie Fabrick	Providence
Jesse Cornett	Kaiser Permanente
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)
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.

- In lieu of introductions to save time, participants were asked to identify themselves in the Chat.
- 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.

Overview

Mellony Bernal reviewed the agenda and provided a brief summary of written feedback received from RAC members after the October 10, 2025 RAC meeting.

Dana Selover shared that written comments received would not be reviewed during this RAC meeting and that staff will analyze further and determine how they may also apply to flagging systems. RAC members were encouraged to review and submit any additional comments.

For this meeting, the RAC will review the rule relating to flagging systems and if time allows review other housekeeping changes.

- RAC member via Chat wondered if there was confusion about what is meant by annual training. Is it prorated per employee (depending on when the employee was hired) versus an annual training that is completed by all staff in a specified time frame. **Follow-up: The OHA believes this topic can be addressed through interpretive guidance.**

OAR 333-027-0125 – Potential Threat or Disruptive Behavior Flagging Systems

RAC members were advised that the text in the rule is, for the most part, identical to language in SB 537. The rule begins with definitions that are specific to this rule only.

Definitions

RAC members were asked whether they had any feedback on the definitions. Discussion:

- In terms of definition for "visual flags," RAC member stated that visual flagging specified in the bill and the rule are an unrealistic expectation for the home environment. Several RAC members concurred. The following comments were made via Chat:
  - Visual flagging in someone's personal space is much more difficult and a burden.
  - Flags occur in community setting already, for example, oxygen, PPE specific for contact or respiratory precautions. It may be more difficult in a home setting versus in a facility, but in practice, visual flags do occur.
  - Patient privacy concerns, including possible mental health related diagnosis.
  - Not all violence is a result of mental illness. It can also be a result of a medical or neurological condition. Signage and visual indicators can enhance caregiver safety without discrimination. Example, symbol or color.
  - Labeling of person's home as a risk for violence is stigmatizing.
  - Opportunity to reframe how to view notifying caregivers about violence. Patients with history of violence would benefit from a care plan that recognizes triggers and seeks to mitigate those triggers for better care. The notification should be seen just like pets, oxygen, guns and any PPE requirements. It is to protect, often solitary clinicians, and should be a bare minimum requirement.
  - Visual flags in home health or hospice setting should be handled differently from a hospital inpatient setting and from an outpatient setting. For example, a flag, sticker, highlight on physical paper-based files for the patient for when access to the EHR is not available. It would not be a sign or mark placed on the patient's home.
  - Informing a patient or a family member that their residence is flagged to warn the care team of a concern for violence may cause a conflict between the care team and family/patient.
  - Flags are intended to create a safe environment for both the patient and clinician equally. The intent is to create a "just in time" type of system.

- RAC member via Chat indicated that where the term "patient" is used for flagging, replace with "patient or caregiver" that may pose a potential safety risk.
- RAC member via Chat asked whether "sexual impropriety/harassment/assault" be explicitly identified in definition for "disruptive behavior."

RAC member noted that the goal is to make sure that people are aware of any potential safety risks. The discussion should focus on how this is best accomplished, making it as consistent as possible, while recognizing the different care settings.

RAC member stated that particularly for pediatrics, flagging needs to include caretakers in addition to the patient, posing a risk to staff.

RAC member spoke to and reiterated via Chat that requiring a linked clinical note that documents justification for the action is cumbersome for nursing, potentially discriminatory to the patient, and the justifications for the flag are within the flag itself. Nurses should not be overburdened with documentation when they are already documenting in EPIC a risk for violence flag, as part of their justification.

It was noted by a RAC member that just because there is a definition for visual flags does not mean the visual flag is mandated. Via chat, it was stated, "Consider writing the rules with flexibility so the requirement is visual and/or electronic flagging. Visual flags may be more appropriate for certain care settings such as hospitals or inpatient care settings, and less appropriate for home health, hospice, outpatient, ambulatory, urgent care settings."

RAC member stated that flagging for possible violence cannot be equated to 'no smoking,' or 'oxygen use.' Information about flagging will eventually get communicated to the patient or caregiver.

Requirements of flagging system

D. Selover shared that details are important when needed but sometimes "less is more" in an administrative rule to allow more flexibility. The rule sets the cornerstones and foundation about what needs to be done and should allow the agencies the flexibility on how to apply, e.g. patients and caregivers. Anything added to the rule must be supported by the legislation.

- RAC member requested that the rule identify a standard length of time for how long a flag is placed on the EHR, and if needed, can be reissued. The flagging system is already discriminatory and should only be in place when absolutely necessary.
  - RAC member shared that for hospice patients, they may only be in care for 1-2 days and expressed concern about the timeline to initiate a flag and expectations.
  - Via Chat, it was noted that removing "an FYI" is more nuanced than a standard length of time. Some people should have flags removed, whereas there are individuals who should never have a flag removed. If there is a requirement for removal, it should

require a risk assessment and an individualized approach. Consider language such as "assess for continued need by the organization at X amount of time."
  - RAC member indicated via Chat that flags for history of violence or elevated risk of violence should not be considered stigmatizing. Flags should be looked at as protective for both the patient and the caregiver. An example was shared of a dementia patient that lashes out. It is not judgmental; rather informative and allows caregivers to take appropriate precautions. The same would apply to other types of situations and patients.
  - Via Chat, a RAC member noted a flag should be "reviewed periodically" and removed when appropriate.
  - RAC member via Chat expressed that the academic research overwhelmingly suggests that flags are discriminatory by nature and disproportionally impact people of color and people with disabilities. Stigmatizing impacts must be thought about.
  - Concerns expressed via Chat about when a flag is placed on a caregiver/family member for potential violence, and that person finds out about it and decides to fire the home health/hospice team.
  - RAC member indicated via Chat, the need to be aware of potentially stigmatizing effect and actively work to counter that, much like teaching people about implicit bias.
  - RAC member stated via Chat, "There was a time that blood-borne pathogens, some of which disproportionately affected historically marginalized populations and people of color, were considered stigmatizing and yet we absolutely notify all clinicians in all care settings to offer clear protections. This is not different."
  - RAC member indicated via Chat that the regulations require training and education for staff authorized to initiate an EHR flag, including training on identifying and preventing bias in the assignment of such flags.
- Rep. Nelson noted via Chat that the bill was not intended to flag someone indefinitely.
- D. Selover provided brief overview of licensing surveys and complaint surveys and enforcement of rules based on question about the creation of a complaint form. A link to OHA's complaint form was shared in the Chat by a RAC member. Anna Davis commented that the OHA focuses on what is measurable, not what is aspirational. A rule needs to be very clear to enforce.
- RAC member stated that there is no evidence to say how often a flag should be reassessed. Evidence base for flagging is specific to acute care; and less evidence exists for home health and hospice. As such, the legislation and rules place Oregon in a leadership role on implementation. Discussion ensued regarding assessing flags periodically, quarterly, etc. or for more violent persons, every day.
- RAC member shared information on a violence assessment tool the was implemented in EPIC, based on observable behavior. A problem when implemented was the flag would disappear after 90 days, and is not helpful if someone is only coming in once year or every six months and is aggressive every time. Assessment is based on observable behavior, so the reassessment would be every time they come in, and if the situation has changed, the flag could drop off. Flexibility is needed for systems to come up with their own policies and procedures.

- RAC members shared articles via Chat:
  - Paterson, J., Fernandes, J., Hunter, K., Hubert, S., & Strudwick, G. (2019). Embedding psychiatric risk flags within an electronic health record: Initial findings and lessons learned. *Healthcare Quarterly*, *21*(4), 54–60. https://doi.org/10.12927/hcq.2019.25739
  - Ferron, E. M., Kosny, A., & Tonima, S. (2021). Workplace violence prevention: Flagging practices and challenges in hospitals. Workplace Health & Safety, 70(3), 126-135. https://doi.org/10.1177/21650799211016903
  - Kopp, Z., Kryzhanovskaya, I., & Garcia, M. E. (2024). Lower the Flag: A Qualitative Analysis of Behavioral Alerts in the Electronic Health Record. Health Equity, 8(1), 762–769. https://doi.org/10.1089/heq.2024.0089 liebertpub.com+1

Restrictions on EHR Flag-Based Actions

RAC member noted that the way the rule is drafted is confusing as it appears that text about conditions that an agency cannot take appears to be under visual flag.

RAC member raised concerns with bill/rule language stating that providers and staff may not deny services to which the patient would otherwise be eligible. Federal CMS Conditions of Participation (42 CFR 418.26) do allow a hospice program to discharge a patient if the patient's (or another person's) behavior is so disruptive, abusive, or uncooperative that it seriously impairs care or the hospice's ability to operate.

- RAC member commented and reiterated via Chat that the rule as written is that these actions cannot be taken "based solely on the presence" of a flag. This doesn't prevent anyone from denying service based on patterns of behavior. The law gives the ability to make an assessment based on ongoing behavior, not just because there is a flag on file.

ACTION ITEMS:

- Consider clarifying that visual flags are not mandatory in all settings; allow flexibility for visual and/or electronic flagging depending on care environment.
- Consider replacing “patient” with “patient or caregiver” when referring to individuals who may pose safety risks and expand flagging criteria to include caretakers, especially in pediatric settings.
- Include “sexual impropriety/harassment/assault” under the definition of “disruptive behavior.”
- Reassess the requirement to link clinical notes for flag justification to alleviate administrative burden.
- Consider defining a standard timeframe for flag placement and reassessment.
- Consider adding language that ensures flags are periodically reviewed and removed when appropriate.
- Ensure that rules do not conflict with federal CMS conditions of participation relating to discharge for safety concerns.
- Review placement of rule text relating to restrictions flag-based actions.

OAR 333-027-0150 – Clinical Records

This rule was amended adding a reference that an agency must comply with electronic and visual flagging requirements in accordance with OAR 333-027-0125. Discussion:

- RAC member suggested that the added language under clinical records is misplaced as the rule is primarily about record retention.
    - D. Selover noted that in the rule, there needs to be a conforming amendment that requires some form of documentation of the flagging. Staff will reconsider placement.

ACTION ITEMS – Reassess where documentation requirements of flagging requirements should be placed in rules.

OAR 333-035-0167 – Potential Threat or Disruptive Behavior Flagging Systems

D. Selover asked whether there were any additional comments for the hospice rules that were not already captured in the discussion above about Home Health Agencies. It was further noted that the Special Inpatient Care Facility (SICF) rules would be skipped and then returned to. Per ORS 442.015, an SICF is a subset of hospitals. Currently, there are only three licensed SICF's all of which are classified as freestanding hospice facilities.

- RAC member reiterated the request that the language about the presence of weapons be revised to align with the bill, specifically, the willingness of the patient to agree to securely store any weapons that are present prior to a home visit.
- RAC member stated via Chat that a definition for SICF should be added to the definitions section and placement of text under OAR 333-071-0423 should be reconsidered. **Follow-up: A definition for SICF is specified under OAR 333-071-0205 - "Special inpatient care facility" (SICF) means a facility with inpatient beds that are designed and utilized for special health care purposes, including but not limited to a rehabilitation hospital, substance use disorder treatment facility, freestanding hospice facility, or a religious institution."**

ACTION ITEMS: Revise all rule language regarding weapon assessment to align with the language used in the bill. Reassess the placement of the training requirement for staff that is currently under OAR 333-071-0423.

OAR 333-500-0025 – Indorsement of Satellite Operations

Staff shared that this rule was updated to require that flagging systems must also be used in hospital satellites. Further information was shared by D. Selover on what is considered a satellite and standards they are held to since they operate under a hospital's license, and they are under the certification of the hospital (i.e. Unity Center.)

- RAC member via Chat indicated that the language used in this rule means that a hospital satellite will be required to use both visual and EHR flagging. Visual could also be cumbersome and might not make sense logistically in all settings for satellites. It was suggested that the language be revised to indicate that visual flags can be used as applicable.

ACTION ITEMS: Consider allowing flexibility in using visual flags in hospital satellite locations.

OAR 333-505-0030 – Organization, Hospital Policies
This rule was amended indicating that a hospital use of identification badges must be in accordance with ORS 441.096.
ACTION ITEMS: None

OAR 333-505-0030 – Organization, Hospital Policies
This rule was amended indicating that a hospital's use of identification badges must be in accordance with ORS 441.096 and that a hospital must adopt and implement a policy for using flagging systems. • RAC member via Chat asked about use of term 'indorsement' versus 'endorsement.'
ACTION ITEMS: Update term 'indorsement' to 'endorsement.'

OAR 333-505-0036 – Hospital Requirements During Emergency Impacting Standard of Care
Staff noted that the rule was amended to align with use of REALD/SOGI terms.
ACTION ITEMS: None.

OAR 333-505-0045 – Potential Threat or Disruptive Behavior Flagging Systems
Similar to the requirements already discussed for Home Health and Hospice, this rule implements the flagging requirements for hospitals. Discussion: • RAC member noted an error in the text referring to hospice services versus hospital. • RAC member suggested as previously indicated about adding to the definition of disruptive behavior references to sexually aggressive or inappropriate behavior.

  - Via Chat, RAC member shared that the definition doesn't preclude other actions that could be considered disruptive, but it does make sense to add sexual harassment explicitly. The DNV accrediting body uses OSHA definitions which are more focused on physical aggression; the Joint Commission has a more broadly inclusive definition of workplace violence. Support the use of a somewhat open definition.

- As previously discussed, RAC member shared concerns both orally and via Chat that the rules are very patient centered when in reality the health care risk is often from caregivers and partners. They reiterated the need to include reference to flagging of caregivers. The shooting that occurred at Legacy Good Samaritan was raised as an example of a patient's partner with ongoing behavioral health and violence concerns and how might the rules address support persons. Several RAC members expressed support via Chat. RAC member further noted that the bar is much higher to remove a partner/caregiver in a pediatric setting, because it is removing a person's rights to be with their child in a vulnerable time.
  - RAC member remarked that there can also be other individuals besides caregivers and support persons, such as family, friends, guests, etc. A broad term should be considered and is essential. It was further noted in the Chat, that this may include animals that are brought into the healthcare environment.
  - Via Chat, RAC member indicated that flagging should be inclusive of all whom the clinician might be required to interact with on behalf of the patient care process.
  - Via Chat, "In the hospital setting "visitor" is a broad term to include caregivers, parents, support persons, etc."
  - Via Chat, RAC member expressed support and indicated that this is why home health and hospice sometimes have to send two staff to complete a home visit.
- RAC member reiterated the need to have a time-limited duration for the flag and for OHA to have a complaint process. The RAC member further inquired whether the patient is notified that they have been flagged. Based on the bill and rule text, there is no requirement to notify a person that they have been flagged.
  - RAC member shared that at their hospital in ICU setting, family members are informed, and risk management is involved. A plan is implemented and may include security standing nearby when staff enter the room. Reassessments occur every 24 hours. Visual cues are used on the doors.
  - RAC member indicated that the importance of notifying someone of the flag is to allow the person to pursue a complaint if they feel like they are being treated differently because of the flag.
  - RAC shared via Chat that there a lot of flags placed in the EHR that don't require notification and are internal hospital processes.
  - Via Chat, patient notification relates to signage that is used as well as the EHR.
  - In the Chat, RAC member indicated that typically any type of flag placed in a patient's chart is not directly communicated to the patient and that includes risk for violence, infection risk, fall risk, etc. Also, typically flags do not show on the patient's access to their medical record as that flags are designed to be internal safety communication/awareness tools.

- D. Selover shared that this is an example of where flexibility may be needed versus having an explicit requirement. There may be other pathways patients/families can express discontent either with the hospital or OHA.

- RAC member shared on the Chat the value of the EHR and visual flags in the inpatient setting for other hospital workers who may need to enter a patient's room, including environmental services staff, phlebotomists, etc. Another RAC member concurred and noted that they often lack information that clinicians have.
- RAC member shared via Chat that some facilities have patient/family advisory groups help develop the process/policy to identify and communicate a patient at risk for violence.

ACTION ITEMS:

- Remove reference to hospice services and revise.
- Consider revising the definition for disruptive behavior to include references to sexual harassment.
- Consider expanding the requirement from patient to a patient's caregiver or support person.
- Consider whether patient/caregiver notification of flagging should be required.

OAR 333-505-0050 – Medical Records

As indicated previously, OHA staff will reconsider the placement of language regarding compliance with electronic and visual flagging in the medical record rule and where documentation requirement may need to be added. RAC members were encouraged to submit additional feedback and suggested rule language via email.

ACTION ITEMS: Reconsider proper placement of compliance and documentation requirements.

OAR 333-535-0035 – Physical Environment Requirements

Staff shared that the Facility Planning and Safety program reviewed and drafted the language being presented in this rule that will require, at time of new construction or during a renovation, emergency department intake windows to have a bullet-resistant barrier or enclosure installed. Staff further shared that the entire rule set is based on the program's adoption of the Facility Guidelines Institute, Guidelines for the Design and Construction of Hospitals. The rule identifies modifications that the program has made to these guidelines, which will now include language relating to bullet-resistant barriers.

- RAC member via Chat noted that the UL 752 Level 3 protection added to rule will protect again all calibers of handgun. In response to a question in the Chat about what level would protect against automatic weapons, RAC member replied that rifle rounds require a much more robust level of protection that is impractical and expensive. Level 3 provides

some protection but will not stop bullets from a long gun. A copy of a chart of the UL 752 ratings was shared in the Chat.

- RAC member asked what would constitute a remodel that would invoke this requirement, such as would changing a countertop now require the addition of ballistic glass. Staff will review and follow-up.
- RAC member stated in the Chat that many ED registration areas are separate from nursing intake (triage areas). The language may only require the registration process. If the intent is to protect during initial intake, language could be altered to include both. **Follow-up: per SB 537, the requirement to install a bullet-resistant barrier or enclosure is limited to the 'emergency room intake window' which is defined as "the designated area within an emergency department of a hospital where patients are registered."**

ACTION ITEMS: Staff will follow-up on question regarding when a remodel in the Emergency Department would trigger the bullet-resistant intake window requirement.

FURTHER OAR REVIEW NOT SUBJECT to SB 537

Additional rules changes were considered that are considered housekeeping in nature or for purposes of aligning with other facility licensing rules.

OAR 333-027-0001 – Compliance with Federal Law
Rule was amended removing outdated language.

OAR 333-027-0046 – Geographic Service Area
This rule is being amended to align with Hospice Program requirements, which allows an agency to serve an area outside the 60-mile boundary for purposes of serving an underserved area or population if the agency can demonstrate the ability to manage and control the services. Since home health is frequently associated with hospice, it was determined that this language should also be adopted for home health. Example provided of being able to provide services to a pediatric patient who may be outside the geographic service area.

- RAC member via Chat suggested that the language under (4)(b) be changed from "the same range of care and services" to the "the same level of care and services" to ensure that the level of care is based on clinical assessment not access to staff.

OAR 333-027-0170 – Waivers
Staff shared that the proposed changes align with recent changes made to the waiver rules for hospitals and requires an assessment of how a waiver may impact populations that may be undeserved. It was noted that the most frequent request for a waiver from Home Health Agencies and Hospice Programs are the geographic service area.

- RAC member inquired about application of waiver and death with dignity in the event that their provider is a religious institution whose policies do not support provider participation in these situations. Staff responded that they have not seen this type of waiver request,

however, there are requests for waivers to be able to serve specific patients that are outside the service area based on services not being met.

- RAC member shared that there is a tremendous shortage of pediatric hospice programs and when patients travel there are very few options, other than seeking a waiver. Staff confirmed that a waiver in this case is possible since it would be easier for the patient to remain with the caregiver that have been working with.

OAR 333-035-0125 – Application for Licensure and Fees
Changes to this rule removed reference to "sufficient" because of ambiguity and replace with language that the hospice program must provide documentation demonstrating that the hospice maintains a workforce capable of meeting demands.

ACTION ITEMS: Under OAR 333-027-0046, recommend changing language under (4)(b) from "the same range of care and services" to the "the same level of care and services."

NEXT STEPS

D. Selover noted that the November 6, 2025 date may be too soon to be able to review all of the comments, conduct necessary research, etc. and propose changes to rule. She asked whether Nov. 10, 2025 might be feasible.

- November 19, 2025 is the deadline to get final rule language to the Public Health Division's administrative rule coordinator in order to be able to post in the December 1 Oregon Bulletin and hold a public hearing in December.
- RAC members remarked via Chat that one final meeting is needed, and a few RAC members noted that Nov. 10th was possible.

Staff suggested that if RAC members have any feedback on how proposed rules may have a financial impact on them to share that information. An email will be sent requesting information.

- A few RAC members via Chat indicated the training requirement would have the most impact.

RAC members were encouraged to submit additional feedback and suggested rule language based on discussion.