EXHIBIT
D-1

OREGON CHAPTER
American College of Emergency Physicians®

OREGON MEDICAL ASSOCIATION

OR-ACEP and OMA comments on SB 537 Workplace Violence Prevention Training Provisions in OSHA Rules

The position of the Oregon Chapter of American College of Emergency Physicians (OR-ACEP) and the Oregon Medical Association (OMA) has been that any mandated training outside of board certification and other licensure requirements may represent an undue burden on healthcare workers.

Preventing violence against healthcare workers has been a long-time priority for OR-ACEP and OMA. They worked with Oregon Nurses Association (ONA) , Oregon Emergency Nurses Association (OENA), and other key stakeholders and legislative champions including Rep. Travis Nelson, on this issue over multiple sessions.

In 2025, Rep. Nelson sponsored a new workplace violence prevention bill at the request of the ONA. Dr. Patsy Chenpanas, OR-ACEP President and OMA member, testified on behalf of both organizations in support of SB 537 and shared her experiences with violence in the emergency department. Dr. Craig Rudy, a member of OR-ACEP leadership, provided written testimony in support of our shared goals to reduce violence and assault in the emergency department.

One concern emergency physicians raised for the Oregon Nurses Association early on in discussions was that the workplace violence prevention training should not be mandatory for health care workers. OR-ACEP did support the requirement that it be made available. We had a common understanding with ONA that the language in the bill accomplished that.

Here it is:
"(b) A health care employer shall provide [assault] workplace violence prevention and protection training to:
(A) A new employee, other than a temporary employee, within 90 days of the employee's in-
itial hiring date.
(B) A temporary employee, within 14 days of the employee's initial hiring date.

(c) A health care employer may use classes, video recordings, brochures, verbal or written training or other training that the employer determines to be appropriate, based on an employee's job duties, under the [assault] workplace violence prevention and protection program developed by the employer."

We raised that issue in the OHA and OSHA rules hearings. OHA's interpretation that the training must be offered versus must attend, for their rules for Home Health. OSHA is taking the stance that it is mandatory for healthcare workers.

We are concerned the OSHA rules may be adding a mandate not included in statute.

Again, OR-ACEP and OMA support having training provided but considers mandatory attendance as potentially shifting the burden of safety from the patient, institution, and environment to the clinician. Many providers are contracted, private practice, or salary based. This means that any new mandated training represents additional work on top of other administrative and clinical responsibilities without additional compensation or protected time. Many clinicians already have a very full schedule and this would take away from other opportunities to help patients. This training is also part of the board certification requirement for emergency medicine physicians and other physicians.

EXHIBIT
D-2

NFIB

August 17, 2026

Lisa Appel
Rules Coordinator
Oregon OSHA
PO Box 14480
Salem, OR 97309-0405
OSHA.rulemaking@dcbs.oregon.gov

Dear Ms. Appel:

RE: Proposed Workplace Violence Prevention Rules for Health Care Employers, OAR 437-002-0150.

The National Federation of Independent Business (NFIB) submits these comments regarding Oregon OSHA's proposed Workplace Violence Prevention Rules for Health Care Employers, including proposed OAR 437-002-0150 and related amendments to OAR 437-001-0295 and OAR 437-001-0706. As the leading small business advocacy organization in the nation, NFIB represents hundreds of thousands of small and independent business owners, including those operating home health agencies and other health care providers throughout Oregon.

NFIB supports the goal of protecting health care workers from workplace violence. No employee should face threats, intimidation, harassment, or violence while performing their job duties. Nevertheless, workplace safety regulations must also consider the operational realities of small employers. As currently drafted, the proposed rule would impose a complex and resource-intensive compliance framework on home health agencies and home hospice providers that lack the administrative staff, dedicated compliance personnel, and financial resources available to large hospital systems.

The proposed rulemaking was initiated to implement Senate Bill 537 (2025), which expanded Oregon's workplace violence requirements and extended coverage to home health agencies and home hospice providers. Oregon OSHA acknowledges that approximately 65 licensed home health agencies and 74 licensed home hospice programs will be affected by these changes.[1] The agency further explains that these newly covered employers will be required to conduct workplace violence assessments, develop and implement workplace violence prevention programs,

[1] Notice of Proposed Rulemaking, p. 5 § (2)(a) (Effect on Small Businesses).

consult with employees regarding workplace violence procedures, provide annual training, investigate incidents, and maintain workplace violence records.

NFIB urges Oregon OSHA to modify the proposed rule to offer greater flexibility and lower compliance burdens for small home health care providers in Oregon, better aligning with their operational realities.

The Proposed Rule Imposes Significant New Costs on Small Home Health Providers

Although Oregon OSHA's Fiscal Impact Statement attempts to estimate compliance costs, NFIB is concerned that it does not fully reflect the realities small employers face.

The Fiscal Impact Statement estimates that the proposed rules will subject home health agencies and home hospice providers to the following time and financial obligations:

- Developing, Reviewing, or Updating Workplace Violence Prevention Programs – A median of 36 hours with an estimated labor cost ranging from approximately $1,125 to over $8,000, depending on who performs the work.[2]

- Developing or Updating Training Guidance – A median of 28 hours at an estimated labor cost ranging from approximately $916 to over $6,000.[3]

- Training Employees on New or Updating Workplace Violence Prevention Program – A median of 22 hours with an estimated labor cost ranging from approximately $720 to almost $5,000.[4]

- Recordkeeping for Incidents of Violence from Training Employees and Entering Incidents – A median of 12 hours at an estimated labor cost ranging from $375 to over $2,600.[5]

Even assuming these estimates are accurate, they demonstrate that compliance will require a meaningful expenditure of time and resources. More importantly, the Fiscal Impact Statement expressly acknowledges that it is not intended to provide an exhaustive accounting of all labor, professional-service, and administrative costs

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[2] Oregon OSHA, Fiscal Impact Statement, Proposed Adoption of Workplace Violence Prevention for Health Care Employers, p. 6–7 (June 26, 2026), https://osha.oregon.gov/OSHARules/proposed/2026/notice-proposed-wpvhc.pdf.

[3] *Id.* at p. 8–9.

[4] *Id.* at p. 9–10.

[5] *Id.* at p. 12.

associated with compliance. Oregon OSHA further recognizes that actual costs will vary significantly depending on the size and operations of individual employers.

For small businesses, the true cost of compliance extends well beyond the direct labor hours identified in the Fiscal Impact Statement. Small home health providers frequently operate with minimal administrative staff. Compliance obligations often fall on owners, nurses, office managers, or supervisors who already perform multiple functions essential to the operation of the business. Time devoted to regulatory compliance necessarily comes at the expense of patient care, scheduling, recruiting, and other business operations.

The Proposal is Based on Assumptions That Do Not Reflect Small Business Operations

The proposed rule appears to be modeled on the organizational structure of hospitals and large institutional health care providers rather than independently owned home health agencies.

The Fiscal Impact Statement repeatedly references employee classifications such as Human Resources Specialists, Occupational Health and Safety Specialists, Emergency Management Directors, Training and Development Specialists, Financial Risk Specialists, and Security Supervisors when discussing compliance activities.

Many small home health agencies do not employ individuals serving in these specialized roles. A small provider may have only a handful of administrative employees, with owners and managers often handling compliance responsibilities themselves. Requirements that may be manageable for large health systems with dedicated compliance, risk-management, training, and security departments can become disproportionately burdensome when imposed on small employers with limited personnel.

The proposed rule should recognize these differences and avoid creating a one-size-fits-all compliance structure that effectively assumes resources many small businesses do not possess.

Annual Training and Program Administration Will Be Especially Burdensome

The proposed rule requires employers to develop and implement workplace violence prevention programs and provide workplace violence prevention and protection training annually.

These obligations create unique challenges for home health providers. Unlike hospitals, home health employees perform services throughout the community and spend much of their time working independently in patients' homes. Pulling

caregivers out of the field for training, meetings, program reviews, and administrative requirements can disrupt services and reduce the availability of care.

These burdens are compounded by employee turnover, which remains a persistent challenge throughout the home health industry. New employees require onboarding, instruction, and compliance training. As turnover increases, so too does the cost of maintaining compliance with recurring training obligations. While Oregon OSHA estimates the costs associated with developing workplace violence programs and training materials, the regulatory analysis does not appear to fully account for the ongoing operational costs associated with repeatedly training and retraining a constantly changing workforce.

Oregon OSHA Should Provide Meaningful Flexibility for Small Employers

The Notice of Proposed Rulemaking specifically requests public comment on whether alternative options could achieve the rule's objectives while reducing the negative economic impact on businesses. NFIB respectfully urges Oregon OSHA to take that invitation seriously and tailor its rulemaking approach to the realities faced by small employers.

At a minimum, Oregon OSHA should consider:

- Creating a streamlined compliance pathway for small employers;
- Providing model workplace violence prevention programs that employers may adopt without significant modification;
- Reducing documentation and recordkeeping requirements for smaller entities;
- Allowing greater flexibility regarding training schedules and delivery methods;
- Extending implementation timelines for newly covered employers; and
- Simplifying reporting and investigation requirements where appropriate.

Such modifications would preserve the rule's workplace safety objectives while reducing unnecessary burdens on small businesses that are already operating under significant workforce and financial constraints.

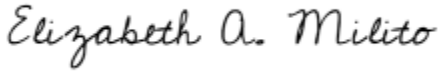
Conclusion

NFIB appreciates the opportunity to comment on this proposal. Small business owners share Oregon OSHA's commitment to safe workplaces and protecting health care workers from violence. However, regulatory requirements must be practical, proportionate, and achievable. As currently drafted, the proposal risks imposing substantial administrative and compliance costs on small home health agencies and hospice providers without adequately accounting for the resource limitations that distinguish these businesses from large institutional health care systems.

NFIB respectfully urges Oregon OSHA to revise the proposed rule to provide additional flexibility, reduce compliance burdens for small employers, and adopt alternatives that

accomplish workplace safety goals without imposing unnecessary costs on Oregon's small business health care community.

Sincerely,



Elizabeth A. Milito
Vice President and Executive Director,
NFIB Small Busines Legal Center

EXHIBIT
D-3

From: Stacey Manclark
To: DCBS RULEMAKING OSHA * DCBS
Subject: OAR 437-002-0150 Workplace Violence Prevention for Health Care - Comment
Date: Wednesday, August 26, 2026 7:15:01 AM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png
image006.png

You don't often get email from stacey.manclark@peoplesafe.co.uk. Learn why this is important

Re: Public comment on proposed OAR 437-002-0150, Workplace Violence Prevention for Health Care Employers

Dear Ms. Appel,

OK Alone provides lone-worker safety technology used by health care organizations and other employers across North America to protect employees who work without direct supervision, including home health and hospice staff who deliver care in patients' homes. We appreciate the opportunity to comment on proposed OAR 437-002-0150 and commend Oregon OSHA for extending workplace violence prevention requirements to home health agencies and home hospice programs under Senate Bill 537. This is a meaningful step: home-based health care staff face real risks of violence, and they deserve the same structured protection as their facility-based colleagues.

We write to highlight one area where the proposed rule could be strengthened for this newly covered population. The rule's framework for hazard assessment, prevention planning, and incident response draws heavily on concepts built for a fixed site: a facility's physical attributes, on-site security staffing, and premises-based investigation procedures. A home health or hospice visit does not have a fixed site. The workplace changes with every visit, there is no facility perimeter or on-site security to rely on, and a worker in distress often has no coworker nearby to call for help. Without guidance that speaks directly to this reality, employers implementing the rule for home-based staff are left to adapt facility-oriented language on their own, and workers may not receive protections equivalent to those the rule intends.

We recommend that Oregon OSHA explicitly recognize lone and mobile workers within its guidance for this rule. Clarifying that terms such as "hazard assessment," "workplace," and "security measures" extend to, and should be interpreted for, home and community-based settings would give employers a clear and consistent basis for compliance and would ensure home health and hospice workers are equally protected.

In practice, employers of home-based and mobile health care workers already have access to a range of practical, outcome-based measures that map directly onto the rule's existing requirements:

- Emergency alerting that lets a worker summon help immediately, supporting the plan's required first aid and emergency response procedures.
- Worker location awareness during a visit, supporting hazard identification and enabling a faster, better-informed response.
- Scheduled check-ins with automatic escalation when a check-in is missed, giving employers a way to notice a problem in real time rather than after the fact.
- Ongoing monitoring that flags a missed check-in or a duress signal to a supervisor or monitoring

service, supporting the training requirement to recognize and respond to an incident in progress.

- Structured incident records generated automatically at the time of an event, supporting the rule's incident log, root-cause analysis, and post-incident investigation requirements.

These are tools already in use across the sector, not a single required solution; we raise them to illustrate that closing the gap for lone and mobile workers is practical and achievable within the rule's existing structure, without adding new categories of obligation.

We support the proposed rule's intent and its extension of protection to home health and hospice employees. We encourage Oregon OSHA to make lone and mobile workers explicit within the final guidance so that home-based staff receive the full benefit of the protections the rule is designed to provide. We would welcome the opportunity to serve as a resource to Oregon OSHA as this guidance is finalized, drawing on our experience supporting health care employers who protect staff working alone in the field.

Thank you for considering these comments.

Respectfully submitted,

Rob Camp,

Senior Vice President, North America, OK Alone




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EXHIBIT
D-4

From: Founding Team
To: DCBS RULEMAKING OSHA * DCBS
Subject: Public comment regarding proposed OAR 437-002-0150
Date: Monday, August 31, 2026 11:32:40 AM

You don't often get email from tactbooknp@gmail.com. Learn why this is important

Public Comment Regarding Proposed OAR 437-002-0150

Workplace Violence Prevention for Health Care Employers

To Oregon OSHA:

Thank you for the opportunity to comment on proposed OAR 437-002-0150. My name is Mel Cortez I am a former registered nurse and clinical violence prevention consultant. My work focuses on helping healthcare organizations translate workplace violence prevention requirements into actual clinical and operational systems, including employee education, behavioral risk recognition, security and clinical response, restraint and physical intervention, incident reporting, governance, and post-incident review.

I support Oregon's decision to broaden the framework from assault prevention to workplace violence prevention. The proposed rule appropriately recognizes workplace violence as more than physical injury and includes threats, harassment, intimidation, assault, homicide, and other threatening behavior. It also establishes requirements for prevention and response planning, workplace assessment, training, incident review, reporting, and employee participation. notice-proposed-wpvhc(1).pdf These are important steps and are consistent with the broader direction of healthcare safety standards in the United States and internationally.

My principal concern is not with the subjects included in the rule. It is with how easily some of those requirements could become separate compliance activities rather than one functioning prevention system. That distinction has become increasingly apparent through implementation work with healthcare organizations operating under similar workplace violence requirements. An organization can have an annual training module, an incident reporting system, a workplace violence committee, a security assessment, and a written policy and still have frontline employees who do not know what to do when a situation actually begins to escalate.

The training provisions are where I believe Oregon OSHA has the greatest opportunity to prevent that outcome. Proposed subsection (4) requires education on predictive factors, escalation cycles, verbal and physical de-escalation techniques, restraint minimization, restraint techniques, self-defense, reporting, behavioral indicators, post-incident support, and active-shooter response. notice-proposed-wpvhc(1).pdf At the same time, subsection (4)(d) permits employers to use classes, video recordings, brochures, verbal or written training, or other methods the employer considers appropriate based on job duties. notice-proposed-wpvhc(1).pdf I am concerned that, without further clarification, this language could allow completion of education to be treated as evidence of operational competency.

This is a very real gap in healthcare. Employees may have completed annual workplace violence education and still be unable to explain when they should activate help, who responds, who leads the response, what their role is, how to position themselves safely, when a behavioral event has moved beyond what one employee should manage alone, or what should happen after the event. I do not believe this is primarily an employee problem. It is a system-design problem.

The Joint Commission's current workplace violence requirements similarly emphasize training based on individual roles and responsibilities and specifically address prevention, recognition, response, reporting, de-escalation, nonphysical intervention, physical intervention, and the respective responsibilities of clinical staff, security personnel, leadership, and outside law enforcement. Oregon's rule would be stronger if its implementation guidance made the same distinction between general knowledge and demonstrated ability to perform assigned high-risk responsibilities.

I would recommend that Oregon OSHA adopt a simple principle: training intensity should be proportional to responsibility. All affected workers need knowledge. Employees with assigned response responsibilities need an opportunity to practice those responsibilities. Personnel expected to perform restraint, physical intervention, or other high-risk response functions should demonstrate competency in those functions. This does not mean every healthcare employee needs a lengthy physical intervention course. It does mean that watching a video or reading a brochure should not, by itself, establish competency to perform a high-risk intervention.

The proposed annual training requirement should also be viewed as a minimum rather than the complete operational model. notice-proposed-wpvhc(1).pdf High-consequence events are difficult to manage reliably when the response process is only revisited once a year. Short scenario-based exercises, shift huddles, tabletop discussions, and brief skills reinforcement can address that gap at relatively low cost. In our implementation work, very short exercises often identify practical problems that annual education does not reveal: employees do not know where the duress alarm is, staff use different terminology for the same level of risk, the front desk does not know what information to communicate, security and nursing have different assumptions about who is responsible for a physical intervention, or employees do not understand when they have authority to disengage from an unsafe encounter.

This approach is consistent with international work in violence prevention. The NHS Violence Prevention and Reduction Standard treats violence prevention as an organizational, risk-based system rather than solely a training issue and uses structured organizational assessment to identify areas requiring action and to measure progress over time. The World Health Organization and its international partners have likewise recommended an integrated approach that includes recognition of violence hazards, work organization, staffing, lone-worker considerations, security measures, worker preparation, incident reporting, monitoring, and evaluation of preventive measures.

I would also encourage Oregon OSHA to give additional attention to how clinical and security personnel are expected to work together during escalating events. The proposed rule appropriately includes contracted security personnel within the training requirements. notice-proposed-wpvhc(1).pdf In practice, however, one of the largest risks occurs at the interface between disciplines. Nursing, behavioral health, physicians, security personnel, administrators, and law enforcement may each have different training, terminology, policy requirements, and

understanding of authority. An event can therefore involve several individually trained professionals who have never been trained to function as one team.

This becomes especially important when restraint or physical intervention occurs. The proposed rule includes restraint minimization, restraint techniques consistent with regulatory requirements, reasonable force, self-defense, and least restrictive procedures. notice-proposed-wpvhc(1).pdf Those subjects should not be treated as separate training topics. A physical intervention in healthcare can simultaneously involve worker safety, patient safety, clinical restraint regulation, security use of force, patient rights, medical assessment, documentation, and organizational liability. Oregon should encourage employers to create a common response workflow defining activation, team roles, leadership, clinical decision authority, physical-intervention responsibilities, documentation, and the transition back to care after an event.

The research underlying the Safewards conflict and containment model is useful here. Len Bowers and colleagues described violence and other safety events as arising from multiple interacting domains, including the patient community, patient characteristics, staff team, physical environment, regulatory environment, and factors originating outside the hospital. That model is important because it moves the analysis away from a simplistic assumption that violence is caused only by an “aggressive patient” or by an employee’s ability or inability to de-escalate. It asks what conditions created the flashpoint and what staff and the organization could change before containment became necessary.

Safewards also provides evidence that relatively simple changes in staff practice and the care environment can affect meaningful outcomes. In a cluster randomized controlled trial involving 31 psychiatric wards across 15 hospitals, the intervention was associated with a 15 percent reduction in conflict events and a 26.4 percent reduction in containment events compared with the control condition. I do not suggest that Safewards should simply be imported as an Oregon regulatory standard; it was developed primarily for inpatient mental health settings. The important lesson is that violence and coercive intervention are influenced by systems, relationships, environment, communication, and staff practice. Training should therefore prepare employees to function within that system rather than merely teach isolated techniques.

I also support the proposal’s requirement that employers assess workplace violence incidents, including attempted violence, perform root-cause analysis, develop plans addressing causes, consider consequences, and review whether security considerations were implemented. notice-proposed-wpvhc(1).pdf I would recommend that Oregon OSHA provide guidance making clear that root-cause analysis should be systems-oriented. Conclusions such as “the employee failed to de-escalate,” “the employee did not follow policy,” or “the patient was aggressive” should not be considered adequate root causes. A meaningful review should consider staffing, workload, communication, patient information, environmental design, alarm availability, response time, training, supervision, previous events, equipment, and whether known risk information was available to the people who needed it.

The Safewards literature again supports this broader view by identifying staff factors, physical environment, regulatory requirements, patient characteristics, patient community, and external circumstances as interacting sources of conflict and containment. The World Health Organization similarly recommends attention to work organization, staffing, lone work, security infrastructure, training, reporting, and monitoring rather than relying on worker behavior alone.

The proposed requirement to include attempted violence is particularly valuable. notice-proposed-wpvhc(1).pdf I would encourage Oregon OSHA to explicitly include near misses in implementation guidance. An employee who recognizes escalating behavior and exits before an assault, a weapon identified before use, an attempted strike that does not make contact, or an event successfully resolved after early activation of assistance may contain more useful prevention information than an injury report. If organizations measure only injuries or completed assaults, they lose much of the information necessary to understand whether prevention is actually working.

For the same reason, I encourage Oregon OSHA to consider the difference between incident counts and prevention performance. An organization with an improving reporting culture may initially report more events because employees begin documenting threats, attempted assaults, and near misses that were previously normalized or ignored. Lower incident counts can therefore represent either improved safety or poorer reporting. A mature program should examine leading and lagging measures together, such as frequency, injury severity, attempted violence, response activation, escalation to physical intervention, restraint or force, reporting rates, corrective-action completion, and recurrence of previously identified hazards.

This is consistent with the Joint Commission's model, which requires not simply incident reporting but analysis of trends, worksite analysis, mitigation of identified risks, multidisciplinary program development, leadership oversight, and reporting to the governing body. The proposed Oregon rule is very close to creating that same feedback loop; additional guidance connecting its individual requirements would make the system considerably stronger.

The incident log also represents an important opportunity. Oregon OSHA notes that the proposed amendments expand the incident log to reflect the broader categories of workplace violence. notice-proposed-wpvhc(1).pdf I recommend ensuring that employers can identify meaningful patterns from that data. At minimum, organizations should be able to analyze specific location or sub-location, work activity, behavioral indicators, precipitating conditions, environmental contributors, response activation, interventions, injury, restraint or force, and corrective actions. An organization that knows it experienced 30 events in an emergency department knows far less than one that can determine that 18 of those events occurred in a particular triage area, doorway, hallway, behavioral treatment room, or registration location.

The same principle applies to behavioral risk communication. The proposal appropriately includes visual cues and other methods of notifying employees about individuals exhibiting behavioral indicators of workplace violence. notice-proposed-wpvhc(1).pdf I encourage Oregon OSHA to emphasize communication of actionable behavioral and safety information rather than labels. The useful information is not simply that a patient has previously been "violent." Staff need to know what behavior occurred, what preceded it, what interventions helped, what increased distress, and what safety precautions are recommended. That distinction protects employees without unnecessarily stigmatizing patients and helps the next employee begin the encounter with better information.

I also recommend explicit closed-loop follow-up for corrective actions. The proposed rule requires employers to develop a plan for addressing identified causes. notice-proposed-wpvhc(1).pdf In practice, the failure point is often not identifying a recommendation; it is ensuring the recommendation is completed. Every meaningful corrective action should have an identified owner, expected completion date, and method for determining whether the intervention worked. Otherwise, organizations can investigate the same hazard repeatedly

without materially changing it.

Home health and hospice warrant particular attention because Oregon OSHA acknowledges that many of these requirements will be new to those settings. notice-proposed-wpvhc(1).pdf A facility-based violence prevention system cannot simply be transferred unchanged into a patient's home. Home-based employees may work alone in environments the employer does not control and may not have security personnel or coworkers immediately available. The WHO's prevention guidance specifically recognizes work organization, lone work, communication, security measures, and prompt response as components of violence prevention. Oregon implementation guidance should similarly address pre-arrival risk information, check-in procedures, reliable communication, known hazards associated with a location or household, authority to delay or terminate an unsafe visit, emergency activation, and communication of newly discovered hazards to employees who may visit later.

The larger point I would respectfully ask Oregon OSHA to consider is that workplace violence prevention should operate as a safety system. Recognition should lead to activation. Activation should lead to a defined interdisciplinary response. The response should generate meaningful documentation. Documentation should produce usable data. Data and incident review should identify corrective actions. Corrective actions should alter policy, training, staffing, environment, communication, or other controls when necessary, and the organization should later determine whether those changes worked.

We are seeing this approach operate effectively in healthcare organizations working under workplace violence requirements similar to those Oregon is implementing. The experience has convinced me that systemization does not necessarily increase regulatory burden. In many respects, it can reduce it. When expectations are translated into clear workflows, standardized training, defined roles, usable data, and closed-loop corrective action, employers have a clearer path to compliance and regulators have better evidence available when an incident or employee complaint occurs. Conversely, when the standard primarily generates policies, annual training records, and disconnected reporting requirements, both employers and regulators are left trying to determine after an event whether a program was actually functional.

I appreciate Oregon OSHA's work on this rule and its recognition that violence against healthcare workers requires a comprehensive prevention framework. Oregon OSHA's own rulemaking materials cite California, Washington, NIOSH, the Joint Commission, and broader healthcare workplace violence research as sources considered during development of the proposal. notice-proposed-wpvhc(1).pdf I would encourage the agency to continue looking internationally as implementation guidance develops, particularly at the NHS Violence Prevention and Reduction Standard, WHO/ILO/ICN/PSI workplace violence guidance, and the conflict-and-containment research associated with Safewards.

I would be glad to share implementation observations, workflow examples, training lessons, or other technical information from our ongoing work if that would be useful or appropriate to Oregon OSHA. My purpose in offering that assistance is not to seek endorsement of a particular vendor or program, but to support the agency's effort to translate this rule into something that is workable at the bedside and measurable at the organizational level. If Oregon OSHA convenes future technical discussions, implementation workgroups, or stakeholder conversations regarding training competency, healthcare response systems, incident data, restraint and physical intervention, or program evaluation, I would welcome the opportunity to participate.

Thank you for considering these comments and for Oregon's work to strengthen protections for healthcare workers.

Respectfully,

Melissa Cortez
Founder, TACTBook
Clinical Violence Prevention Consultant
Tactbooknp@gmail.com
512-534-8417

Selected References

Bowers L, James K, Quirk A, Simpson A, Stewart D, Hodsoll J. *Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial.* International Journal of Nursing Studies. 2015;52(9):1412–1422. The trial reported reductions in conflict and containment associated with the Safewards intervention.

Bowers L. *Safewards: a new model of conflict and containment on psychiatric wards.* Journal of Psychiatric and Mental Health Nursing. 2014;21(6):499–508. The model identifies six interacting domains contributing to conflict and containment.

Bowers L, et al. *Safewards: the empirical basis of the model and a critical appraisal.* Journal of Psychiatric and Mental Health Nursing. 2014. This review examined the empirical basis for the model across more than 1,000 publications while also recognizing limitations in the strength of the underlying evidence.

NHS England. *Violence Prevention and Reduction Standard*, Version 2. The standard provides a risk-based organizational framework for violence prevention and reduction and includes structured organizational assessment and improvement.

World Health Organization, International Labour Office, International Council of Nurses, and Public Services International. *Framework Guidelines for Addressing Workplace Violence in the Health Sector.* Geneva; 2002. The framework addresses prevention as an organizational and systems issue adaptable to differing healthcare environments.

World Health Organization. *Violence and Harassment: Occupational Hazards in the Health Sector.* WHO identifies work organization, staffing, lone-worker considerations, physical security, worker preparation, reporting, trend monitoring, and evaluation as components of prevention.

The Joint Commission. *National Performance Goal #2a: Preventing Workplace Violence* and associated workplace violence prevention requirements. The requirements address multidisciplinary leadership, training based on roles, reporting and trend analysis, worksite analysis, mitigation, post-event support, and governing-body oversight.