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Task Force on Improving the Safety of Behavioral Health Workers

September 10th, 2024
Meeting #4: Safety Plans and Training (continued); Staffing Levels (new)

Roll Call

Please have camera on and microphone unmuted

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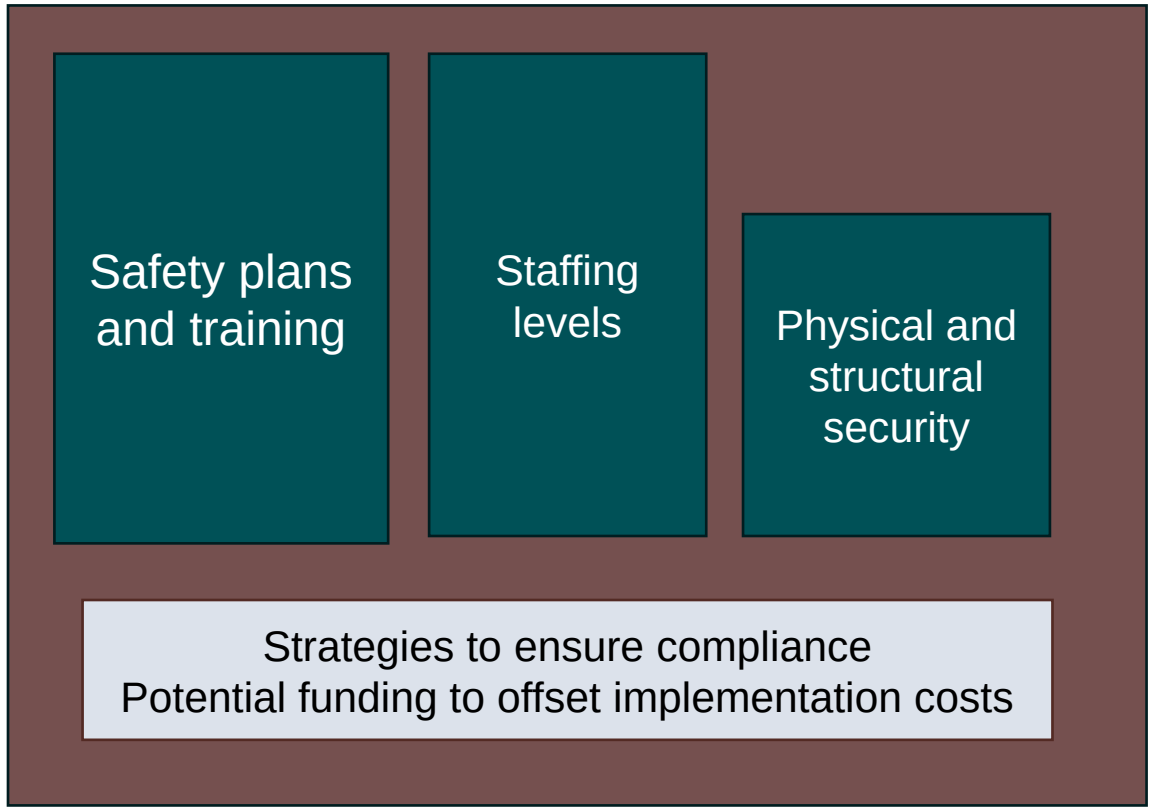
Workplan: Today



Draft Workplan	
Today	Scoping/Workplan
Aug 30th	Safety Plans
Sept 10th	Staffing Levels
Oct 3rd	Structural Security
Oct 16th	Draft Recommendations
Nov 7th	Draft Report
Nov 14th	Adopt Report

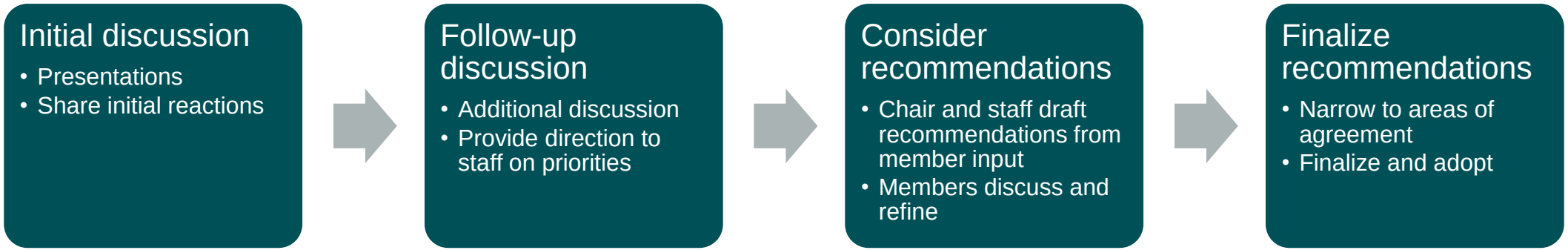
Agenda for Today

September 10th, 2024

- Review violence-related training rules
- Discuss member priorities for safety plans, trainings
- Lone worker policies
- OHA behavioral health reimbursement and staffing level requirements

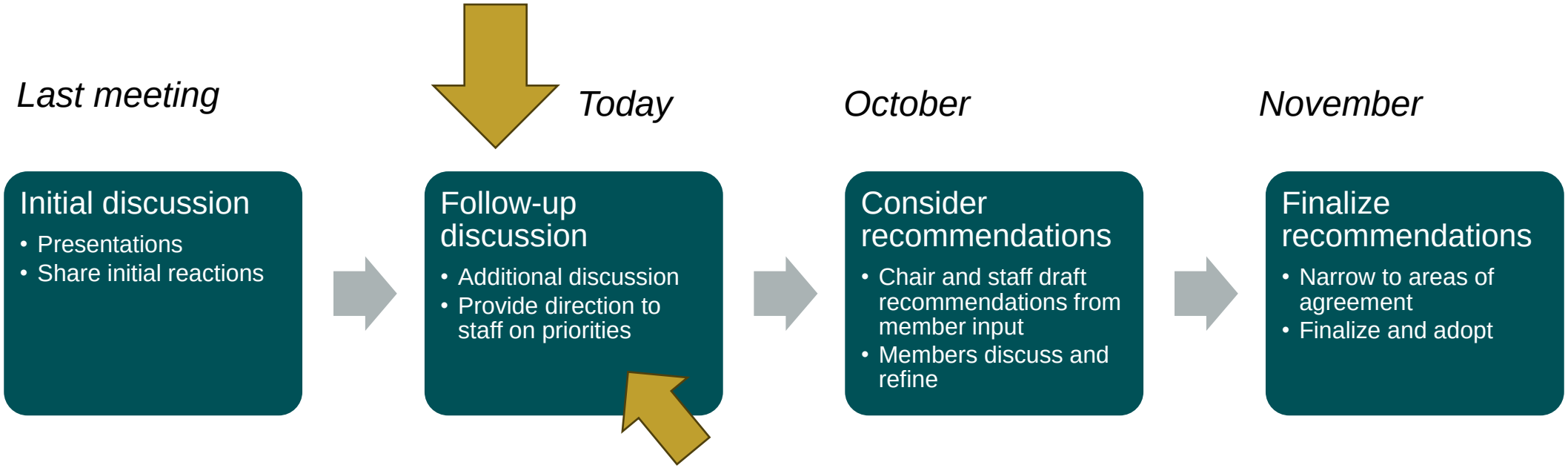
Getting to recommendations

*Within each of the 3 policy domains:**

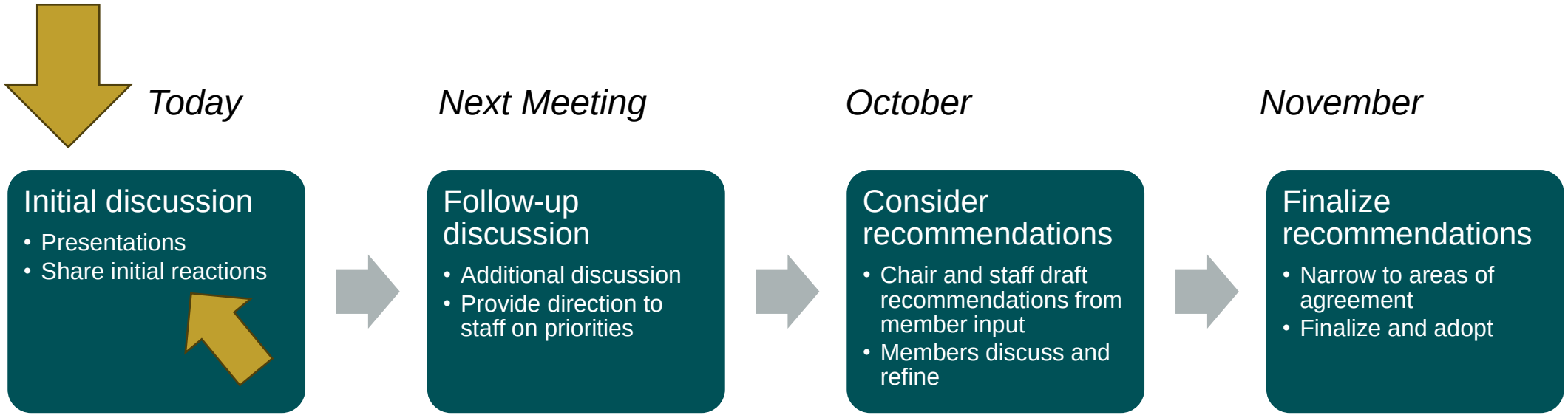


** 1) Safety plans, 2) staffing levels, and 3) physical/structural security*

Safety Plans (Topic 1)



Staffing Levels (Topic 2)



Violence-Related Trainings in Behavioral Health Settings

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Recap: What We Heard From You on Training

- Trainings are not meeting current needs – options too prescriptive, content vague or wrong topics
- Trainings should NOT be one-size-fits-all; allow settings to choose from approved list
- Greater emphasis needed on training workers in the first 90 days
- Cover specific topics
    - Field safety (including how to safely drive and transport clients; options during severe weather/climate events)
    - De-escalation and evasion (CPI-NCI training is not meeting needs)
    - What to do if a client needs a higher level of care
    - How to call for help in an emergency; coordination with law enforcement
    - Incorporate role-play and practicing de-escalation techniques
- More tailored training is useful for specific audiences (aides, nursing staff, mobile crisis)
- Role of supervisors is important for reinforcement and support to apply trainings to real-world events

Agency Training Requirements

In your meeting materials:

OHA/ODHS regulatory requirements for de-escalation training for

- **Institutional providers**
  - acute hospitals, psychiatric, ED, secure transport, etc.
- **Home and community-based providers**
  - residential, foster homes, structured housing
- **Other***
  - mobile crisis, outpatient care, detox centers, supported employment, child care

** No information obtained for shelter providers*

Highlights

- Most settings have regulatory requirements for de-escalation training/techniques
- Varying level of detail, prescriptiveness, content
- At ODHS, curricula include:
  - The Mandt System
  - Crisis Prevention Institute
  - Oregon Intervention System (Alternative Services of Oregon)
  - Collaborative Problem Solving (Think:Kids)
- At OHA, certain curricula pre-approved but no specific curriculum is mandated

Discussion: Member Priorities for Safety Plan Recommendations

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Recap: Oregon OSHA Rulemaking

Oregon OSHA requirements include:

- **Specific** workplace violence prevention rules for hospitals, surgical centers (ORS 654.412-423)
- **General** duty clause for all other health care settings including behavioral health. General duty requirements are more difficult to enforce and provide less clarity to employers on how to comply.

Oregon OSHA can develop new rules:

- At the direction of the legislature or Governor
- When federal OSHA adopts a new rule
- When unions, industry groups, or others flag emerging trends and new hazards

Recap: Existing Oregon OSHA Rules

All employers in Oregon are required to have a **workplace safety committee** that meets monthly, identifies hazards, investigates injuries, and makes recommendations to the employer.

- requirement primarily enforced through complaints
- some elements may be difficult to meet during severe staffing shortages

Certain existing OSHA requirements apply only to select employers:

- **Hospital** requirements include violence assessments, safety plans, training, assault logs.
- **Health care** workers cannot be required to work alone with a client who has assaulted them previously.
- **Home health** workers can require 1) a communication device, or 2) a second worker be present when concerned about risk of violence.

Recap: The Joint Commission's Standards

January 2024: The Joint Commission published standards for workplace violence prevention for voluntarily accredited behavioral health and human service organizations.

Standards include:

- **Leadership:** organizations must have "a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team";
- **Worksite analysis:** organizations must conduct "a worksite analysis related to its workplace violence prevention program" and take action to mitigate or resolve based on findings of the assessment.
- **Monitoring:** The organization must also have a process to collect data to continually monitor, internally report on, and investigate safety and security incidents.
- **Training:** organizations must provide training, education, and resources on its workplace violence prevention program at the time of hire, annually, and whenever changes occur.

Workplace Violence Prevention Resource Center offers published tools and information to support implementation

Recap: Preventing Retaliation

Oregon Safe Employment Act:

- Protects workers from **retaliation** when they complain about workplace hazards (including risks of violence) or violations of OSHA rules
- Establishes a worker's **right to refuse** work in certain conditions when there is a danger of serious physical harm

BOLI investigates violation of these rights through its Civil Rights Division.

The statute of limitations is one year.

If a worker has complained about a workplace hazard and the employer takes an adverse action, there is a presumption that retaliation *has* occurred unless the employer can prove the two acts are not connected.

Next Steps

Safety Plans and Training

- Any new reflections on **safety plans and training***
- Discuss your priorities for recommendations
- Staff will work with Chair on first draft based on member discussion
- Further review at an upcoming meeting

*Reminder: staffing levels, reimbursements, and physical/structural security to be covered separately

Next Steps: Issues and Ideas

Issue	What would help?
Employers and workers experience tension between OSHA's rules for worker safety and OHA/ODHS requirements for client care. Pressure to place clients in "any available bed" increases the risk of violence when clients are placed in settings that do not meet their needs.	• Collect examples from providers of where/how regulatory tension occurs across agencies? • Develop agency guidance on how to be compliant with regulations in common BH violence situations? • Develop trainings that address these situations? • Increased coordination among OSHA, OHA, ODHS in regulatory enforcement?
Violence resulting from mental illness may not meet OSHA's definition of assault. Required assault logs will not capture these events under current rules. Staff may be uncomfortable classifying these as assaults despite need for tracking. Filling out logs is too time consuming.	• Change definition of assault? • A different type of incident log or tracking system for behavioral health violence? • Capture non-assaults or "near misses" in assault log? • Reduce burden of maintaining assault log
Safety plan requirements need to include shelters, mobile crisis, and other community settings. Challenging to impose new requirements through OHA/ODHS licensing functions because settings are regulated through different pathways, if regulated at all.	• Expand OSHA's requirements for hospitals to cover other behavioral health settings? • Enhanced technical assistance for certain employers to comply with existing OSHA rules? • Use risk assessments for liability insurance as a pathway to enhanced planning?

Next Steps: Issues and Ideas

Issue	What would help?
Current de-escalation trainings are not meeting needs. Either too prescriptive, not relevant to setting, or not detailed enough to be useful. Trainings are not widely available to all workers who need it.	• More agency options for de-escalation trainings? • Require trainings for shelters, mobile crisis? • Trainings to address common BH violence challenges and which responses meet agency requirements?
Employer safety plans are not consistently happening. Regulatory enforcement is reliant on complaints. Workers are not consistently trained during onboarding and may not know their rights or what is reportable. Worker turnover undermines training effectiveness.	• Require plans be written down and accessible to all workers? • Trainings to address worker rights and reporting options? • Expand how workers access trainings. Offered through agencies and labor-management trust? • Increase requirements/enforcement of trainings in first 90 days?
Administrative rules for facility regulation are not developed from a worker safety lens. Training requirements may not address safety adequately or at all.	• Direction to agencies to review rules and develop any new rules for BH settings with specific consideration for worker safety? • When rules relate to client neglect or abuse, include explicit guidance on assaultive behaviors?

Discussion

Safety Plans and Trainings

With regard to **safety plans and trainings**:

Are these the primary issues?
Are these the right strategies?
Where could more detail be added?
Do you have concerns about any of the strategies listed?

Break

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Topic: Staffing Levels

Domain 2

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What we heard from you so far re: staffing levels

- Current OSHA requirements are undermined by staffing shortages
    - Behavioral health employers are widely impacted by staff shortages
    - Impedes participation in safety committees, filling out assault logs, participating in training to know rights and report violations
- Minimum staffing levels
    - workers should not be required to work alone in unsafe situations
    - lower client-to-staff ratios could reduce access without additional hiring
    - new staffing requirements would need to account for team-based care models commonly used in BH care
    - employers need guidance on what to do when minimums cannot be met
- Paying to achieve minimum staffing levels
    - Medicaid reimbursements should align with staffing requirements; incremental acuity-based rates (15 minutes, etc.) may not support hiring as intended, especially for small providers
    - Task Force recommendations would ideally engage with other payment redesign conversations

Lone Worker Policies

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What is a Lone Worker?

- Any employee in a situation or location without a colleague nearby, or where the employee works without close or direct supervision[1-2]
- Work across a wide variety of settings and industries
    - Including working separately at a fixed worksite, working offsite, mobile work, and late shift work
- Usually encounter the same hazards as other employees but may be at an increased risk of experiencing workplace incidents with adverse outcomes of greater severity[3]
    - May be vulnerable to violence/aggression
    - Health care and social service workers are particularly vulnerable to workplace violence, with those working alone at a greater risk[4]

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1. Health and Safety Executive. 2020. *Protecting lone workers: How to manage the risks of working alone*.
2. National Health Service Employers. 2022. *Improving the personal safety of lone workers*.
3. National Safety Council. 2023. *Work to Zero: Using lone worker technology to protect workers*.
4. Occupational Safety and Health Alliance. 2016. *Guidelines for preventing workplace violence for healthcare and social service workers*.

Overview of Lone Worker Policies

- Encompass a broad category of policies put in place to mitigate safety risks for lone workers
- Components of lone worker policies include:
    - Assessing and managing areas of risk, establishing training requirements, and putting systems in place to maintain communication
- Federal OSHA does not have a comprehensive standard for lone workers across industries, however some general and industry-specific standards exist
    - Shipyard employees (OSHA 1915.84)
    - Entry into confined spaces (OSHA 1910.146)
    - Hazardous waste operations and emergency response (OSHA 1910.120)

Examples in Health Care

- The National Health Service (NHS) widely utilizes lone worker policies across the UK
- NHS employers are required to address five key areas for lone workers:

1. National Health Service Employers. 2022. *Improving the personal safety of lone workers*.

Examples in Oregon – OSHA/BOLI Regulations

Oregon Safe Employment Act

- Workers have the **right to refuse** work when there is a danger of serious physical harm or death, there is insufficient time for OSHA to inspect, and the employee has been unable to obtain correction of the dangerous condition from the employer. (ORS 654.062)
- A **hospital or surgical center** employee who has been assaulted by a patient can require that another worker be present in any future treatment of that patient (ORS 654.418)
- A **home health worker** can require a second employee to be present when treating a patient if the employee believes the patient may assault them (based on the patient's past behavior or physical or mental condition) (ORS 654.421)
- A **home health worker** can require a communication device for reporting assaults before treating a patient (ORS 654.421)

Washington State SHB 1456 (2007)

The Marty Smith Law[1]

- Enacted in 2007 in response to the death of Marty Smith, a Designated Mental Health Professional (DMHP) who was killed in 2005 while responding to a house call

Key Components of SHB 1456[2]

- Prohibits crisis workers from being required to respond to calls at private locations without being accompanied by a second trained individual, based on clinical judgement
- Requires wireless communication devices for staff responding to private locations
- Requires DMHP and crisis service providers to maintain a written policy covering training, staffing, information sharing, and communication for staff responding to private locations
- Requires prompt access to patient histories
- Requires annual worker training on safety and violence prevention

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1. Gunn, Tina. 2007. “Marty Smith bill aims to protect mental health workers.” *Kitsap Sun*, February 2, 2007. https://archive.kitsapsun.com/news/local/marty-smith-bill-aims-to-protect-mental-health-workers-ep-423260844-359103401.html/.
2. Marty Smith Law, S.H.B. 1456, 60th Leg, WA (2007).

Implementation of SHB 1456

Violence Prevention Training (RCW 49.19.030)

- The violence prevention plan of the specific setting
- General safety procedures
- Violence predicting behaviors and factors
- The violence escalation cycle
- De-escalation techniques
- Strategies to prevent physical harm with hands-on practice/role play
- Response team processes
- Proper application and use of restraints
- Documentation and reporting of incidents
- The debrief process following an incident
- Resources for employees for coping with the effects of violence

- Washington's experience following the implementation of SHB 1456 in 2007

Behavioral Health Reimbursement and Requirements for Staffing

Sam Byers, Adult Behavioral Health Director, OHA

Donald Jardine, Medicaid Behavioral Health Policy and Programs Manager, OHA

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Discussion

Staffing Levels

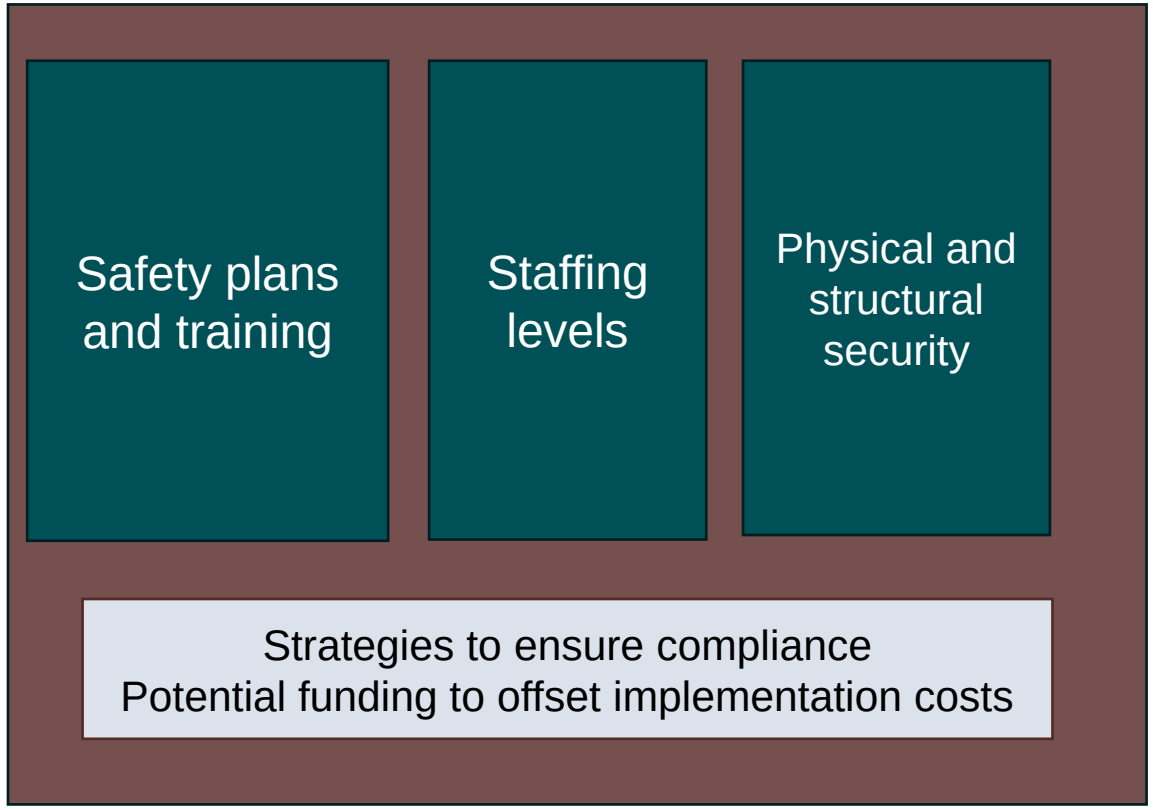
What would help workers and employers have more time for current OSHA-required activities?

Where could lone worker protections be more relevant to BH settings?

Where could the connection between staffing levels and payments be stronger?

What other opportunities exist related to staffing?

Next Steps



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