Meeting Summary

Joint Task Force on Improving the Safety of Behavioral Health Workers

Meeting #4

Link to Task Force on OLIS

Date/Time	September 10, 2024 (link to recording)
Attendees	Rep. Travis Nelson, Chair Rep. Cyrus Javadi, Vice Chair Devarshi Baipai Ryan Bell Dave Boyer Clay Cruden Stacy England Jeremy Lankenau Alexander Mackaben Anna Peña Eric Sevos Matt Swanson Sommer Wolcott Penny Wolf-McCormick Excused: Sen. Lynn Findley, Sen. Chris Gorsek, and Linda Patterson
Review of workplan and agenda LPRO Staff	LPRO staff reviewed the agenda for the meeting and workplan. In addition, staff reviewed a process that the Task Force can use to develop and approve their recommendations.
Informational Meeting: Safety Planning and Training LPRO Staff	LPRO staff provided a recap of the points task force members identified regarding training in the needs assessment. Staff summarized employee training requirements from Oregon Health Authority (OHA) and Department of Human Services (DHS). Task force members shared the following perspectives on safety trainings: • Peña noted the importance of accessibility and consistency in safety trainings. It was explained that while it is important to develop these trainings, it is also critical to ensure that the trainings reach the staff members who carry out the work and that there is consistency of training requirements. In addition, trainings should be specific to the work environment and provided in accessible ways, meaning written down and available to staff when needed. ▪ Chair Nelson asked Peña whether other states had written requirements that would be of interest here. None were noted at the time. • Swanson noted that specific de-escalation trainings could be important in community-based care settings, particularly in-home care. These trainings may happen during on-boarding processes, but the addition of accessible resources could help support continued de-escalation training, particularly in situations where staff are working alone.

- Peña added that, even where employers have extensive safety plans, they may be lacking the resources and staffing to execute those plans.
- Wolcott shared that existing legislative mandates restricting the use of walls, floors, and chairs while stabilizing a violent patient have created challenges in children's psychiatric settings. The mandates have effectively restricted the use of some population-specific de-escalation tools (i.e. Therapeutic Crisis Intervention and Pro-ACT) in residential settings. Providers end up limiting intervention for children with violent behaviors or compromising employee safety.
- England noted an interest in seeing more state-sponsored trainings. With train-the-trainer models (such as Pro-ACT), it can be challenging to manage trainings if staff turnover includes trained employees.
- Swanson indicated that standardized trainings could be helpful in addressing staff mobility and churn across care settings. At the same time, training recommendations should also consider existing system strain and whether resources can be made available to support implementation of new requirements. Specific questions raised included whether federal investment could support implementation, if a bonus could be made available for certain staffing structures, and resources could be tied to training outcomes to help address organizational barriers to implementing training requirements.
- Sevos noted that not all staff are trained in risk assessment and that it would be helpful to receive guidance from the state to support skill development in this area for staff at all levels, particularly tools for assessing and thresholds for when to go to a higher level of risk assessment.
- Mackaben noted that low-barrier shelter staff need resources for supporting non-violent clients who are at risk of harming themselves beyond response from law enforcement.
    - Lankenau added that law enforcement involvement is necessary in situations where clients need to be involuntarily hospitalized and there is a risk of violence to crisis response staff.

Informational Meeting: Discussion: Member Priorities for Safety Plan Recommendations Rep. Travis Nelson, Chair	Chair Nelson led the Task Force in a discussion of Task Force member priorities for safety plan recommendations. The goal was to provide guidance to staff to develop a first draft of recommendations for Task Force members to consider at an upcoming meeting. The discussion included review of a list of issues, whether the issues are primary, whether the potential strategies identified are appropriate, and where more detail could be helpful or Task Force members had concerns for each issue. Task Force Members reviewed the table in staff slides (see slides 17-18) and shared the following points on table contents.

Issue: De-Escalation Trainings	
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.	
What would help?	**Member discussion**
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?	England noted that "de-escalation" training can sometimes be used interchangeably with "safety" training, however they are distinct (for example, calming a client down vs getting away from a dangerous situation). De-escalation is a component of safety training but not the entirety of it. It was noted that because organizations each set their own de-escalation trainings, is difficult to say that trainings are not meeting needs, though there are some beneficial trainings available. It was also noted that receiving field safety training may be more of a concern for mobile crisis responders who are required to receive de-escalation training. Wolcott agreed that the distinction between the two types of training is important, as it is important to adapt the trainings to the specific work setting and environments. It could be helpful to develop add-on training components tailored to different settings and/or level of care. Train-the-trainer models can be good from a fidelity perspective but can be limited by staff turnover and restrictions on training across agencies. Lankenau agreed with Wolcott's comment that train-the-trainer models are an effective format. It was noted that these trainings can account for what is happening on the ground in real time, but being too prescriptive with training requirement can lead to trainings becoming outdated over time. Chair Nelson asked how members felt about requiring employees to attend in person trainings, noting that in-person trainings are often more valuable than online modules, however in-person training is more expensive than online modules. Lankenau noted that union contracts may have provisions requiring supervisors to meet with supervisees monthly, this could create an opportunity to discuss online training modules on a regular basis which might help avoid in-person training costs. Wolcott agreed that in-person trainings are preferable to online where possible, noting that virtual trainings for

smaller or remote agencies should be real-time and interactive.

England agreed with the value of in-person training but added that training frequency can be challenging as not all staff can be pulled into a single training at the same time. Online trainings provide more flexibility, particularly for small teams. If regular virtual trainings could be offered by a single entity such as the state, that could allow for easier attendance with less strain on teams.

Chair Nelson asked whether there is anyone at the state who can provide these trainings to organizations. England noted that for mobile crisis trainings the state has contracted with the Association of Oregon Community Mental Health Programs (AOCMHP) to provide an academy-style training semi-annually.

Chair Nelson asked whether de-escalation trainings could be required upon hire and then as a refresher every 3-4 years. England noted that this is a good approach but still difficult to carry out when staff are hired intermittently throughout the year.

Wolf-McCormick added that OSHA is not prescriptive about the specific training, just the components included. It was also noted that trainings with an interactive component tend to be more successful and that it is important for trainings to be site-specific.

Sevos noted that it is important for employers to drill training skills regularly and that this does not happen.

Wolcott added that available trainings have set training frequency and refresher guidelines but this can be challenging for smaller agencies that hire throughout the year. Offering virtual trainings could be helpful for getting new employees in the field until an in-person training can be attended.

Issue: Safety Plan Consistency

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.

What would help?	Member discussion
Require plans be written down and accessible to all workers?	Swanson expressed an interest in developing training partnerships, noting that safety culture is important and that partnerships can leverage more resources beyond what a single employer can offer.
Trainings to address worker rights and reporting options? Expand how workers access trainings. Offered through agencies and labor-management trust?	Wolf-McCormick noted that it is helpful when the plan is in writing (Swanson agreed) to allow employees to access the information as needed (ORS 654 does not require written plans). It was expressed that it is concerning that hospital employees can work up to 90 days without training. Chair Nelson asked which standard would be better and Wolf-McCormick added that training should be required before the employee is exposed to the hazard.
Increase requirements/ enforcement of trainings in first 90 days?	Chair Nelson asked what penalties for non-compliance look like. Wolf-McCormick noted that OSHA penalties changed in January 2024 when they increased by about 10x, employers with multiple penalties receive higher fines and smaller employers may be eligible for a small deduction in fines. Employers in non-abatement receive daily penalties after 7 days. OSHA does not inspect every employer routinely. Chair Nelson asked that penalties be captured in the record, and sees them as a mechanism for enforcing that trainings be required within the first 90 days of employment. Swanson asked whether, in addition to penalties, a bonus payments or other incentives could be offered to encourage compliance. England added incentive payments are currently offered once a goal is met, rather than to support achieving the goal.

Issue: Administrative Rules

Administrative rules for facility regulation are not developed from a worker safety lens. Training requirements may not address safety adequately/at all.

What would help?	Member discussion
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?	Lankenau raised Ricky's Law and noted that there could be a recommendation to change administrative rule for co-occurring conditions. Wolcott added that administrative rules prioritize client/patient rights but do create space for employers to protect employees when treating violent or dangerous clients. Finding a balance can be difficult. Adult SRTFs prohibit considering a person's behavior within 14 days prior to admission, but this could be addressed with a recommendation.

Issue: OSHA Worker Safety and OHA/ODHS Client Care Tension

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.

What would help?	Member discussion
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?	Chair Nelson noted that Wolcott's prior comment about administrative rules fits well in this discussion. Wolf-McCormick asked for examples of where providers feel that this tension is happening. Sevos added that residential facilities fall under home/community-based rules which limit what organizations can do to control who enters a program and when. This is tied to how OHA funds programs. Employers experience challenges following state rules while also protecting employees. Wolcott agreed with Sevos, noting that rules allow for overnight guests and visitors which creates tension in trying to create a home-like setting while protecting employees. Settings have been retrofit and may not be designed to support the level of acuity of treatment.

Develop trainings that address these situations?	Facilities cannot create a home and community-based services environment while maintaining a safe treatment environment for staff.
Increased coordination among OSHA, OHA, ODHS in regulatory enforcement?	Sevos added that the Legislature could allow employers to license residential programs outside of the waiver; this could enable the creation of short-term residential programs that are treatment-focused rather than home-focused, though this would be challenging for the state. Bajpai asked if this is an issue elsewhere in the behavioral health system. Wolcott noted that there is a tension with developmental disability services, though less relevant in detox or substance use treatment facilities. England added that this is becoming relevant in mobile crisis, and there is tension over when to send staff to potentially dangerous calls due to a lack of clarity around response requirements in dangerous situations.

Issue: Assault Definition

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.

What would help?	Member discussion
Change definition of assault?	Bajpai noted that changing the definition of assault does not make sense as the language in OSHA mirrors criminal code, creating a new category could make sense.
A different type of incident log or tracking system for behavioral health violence?	Wolf-McCormick noted that capturing near-misses and any violent incidents can be helpful in a log. Chair Nelson asked whether Senator Prozanski was doing work on assault definitions. Mackaben added that a written assault/violence log can be useful in developing a safety plan.
Capture non-assaults or "near misses" in assault log?	Cruden added that having an after-action meeting could be important after an incident and as a training tool. Chair Nelson noted that this could be like a root cause analysis.
Reduce burden of maintaining assault log	Lankenau noted that a critical incident form/review can capture near-misses which can support process improvement when used with an after-incident follow up plan.

Issue: Safety Plan Settings	
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.	
What would help?	**Member discussion**
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?	England shared concern over using hospital standards due to the size of hospitals and the associated administrative burden. Community settings send to be different in size and capacity. Bajpai echoed these concerns, adding that highest risk clients tend to end up in the hospital. Chair Nelson asked what enhanced technical assistance would look like and whether that would mean OSHA being more responsive to feedback. Wolf-McCormick echoed the question, adding that consultation is available to employers and that trainings are available but the sense is that employers are not seeking out workplace violence assessments. Lankenau asked whether this could look like OSHA staffing positions dedicated to behavioral health. Wolf-McCormick responded that asking for additional funding is challenging, adding that OSHA typically comes in after an incident has occurred and questioned how to get employers invested in violence prevention. Advertising was floated as a potential avenue to increasing utilization. Chair Nelson asked Wolf-McCormick to look into whether OSHA consultants are currently doing prevention work. England asked whether this could fall into a recommendation to require written safety plans. Chair Nelson noted that this is related to who is required to have a safety plan. Wolf-McCormick added that having a safety plan is very important, though could be paired down to limit burden. Cruden asked whether this could be employee-driven or made part of an employment packet to increase visibility, like signage on hourly wages and other required postings. Chair Nelson asked Wolf-McCormick whether safety plans are required to be collaborative between employers and employees. She replied under ORS 654, most are collaborative as employees have the on-the-ground

	perspective. Chair Nelson echoed the value of collaborative plan development.
Informational Meeting: Overview of Lone Worker Policies LPRO Staff	LPRO staff provided a recap of the provisions of the Oregon Safe Employment Act and ORS 654 as well as an overview lone worker policies.

Lone Workers:

- Any employee in a situation or location without a colleague nearby, or where the employee works without close or direct supervision.
- Work across settings and industries, may be employees working separately at a fixed worksite, working offsite, mobile work, and late shift work.
- Encounter similar hazards to other workers but have an increased risk of experiencing incidents and have greater severity with adverse outcomes. Lone workers are at a high risk of harassment, aggression, and violence, especially in health care settings. Working alone can make it difficult to access emergency services.

Lone Worker Policies**:**

- Broad category of policies to mitigate safety risks specific to lone workers
- Components include: assessing and managing areas of risk, establishing training requirements, and putting systems in place to maintain communication
- No comprehensive Oregon or federal OSHA standard, some federal industry-specific policies for things like shipyard workers (OSHA 1915.84), confined space entry (OSHA 1915.84), hazardous waste, and emergency response (OSHA 1910.120).
- *Health Care*
    - Not commonplace in the US, though widely utilized in the UK throughout the National Health Service (NHS) where employers are required to have policies that address five key factors:
        - **Risk assessment** - identifying who could be harmed, what harms may occur, and how these harms might be prevented or mitigated; should be specific to the job and the work environment, the patients receiving care, and the employee's competencies and level of training
        - **Prevention** - the employer must first eliminate the job hazards wherever possible (e.g. requiring that the patient be treated in a different setting or that an employee is accompanied by a colleague). Where lone work is required, the employer must invest in implementing a safe system that addresses risks, including panic buttons. Communication technology must provide location and emergency contact information in the event that the employee requires assistance
        - **Policy** – Organizations are required to have a policy in place that informs lone workers about these systems,

including roles and responsibilities, who is responsible for implementing each component of the policy. The policy must cover prevention and after incident protocols. Policies are required to be communicated to all employees who engage in any amount of lone work and those who interact with those lone workers and may be involved in the actions outlined in the policy.

- **Training** – Employers are required to provide training and to identify each employee's training needs as a component of risk assessment.
- **Support** – Following an incident or a "near miss" related to violence or aggression, there must be a system to respond, such as investigation and adapting systems to better prevent the situation from happening in the future, providing information on counseling, and liaising with law enforcement as necessary.

Washington State SHB 1456 – Marty Smith Law (2007)

Enacted in response to the death of a Designated Mental Health Professional (DMHP) who was killed in 2005 while responding to a house call.

Key Components of SHB 14562

- 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, prevents retaliation for refusal to go to a home visit alone following consultation with a clinical team.
- 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

A prior version of the bill which included mandatory staffing minimums (specifying a second DMHP staff member) stalled in the Senate in 2006 due to concerns over the fiscal impact.

Funding associated with the bill was included in the 2007-2009 Biennial Budget and appropriated to a DSHS division now within the Washington Health Authority. The appropriation in 2008 was $2,021,000 from the general fund and $1,683,000 for fiscal year 2009.

A curriculum was developed by a steering committee representing a diverse group of stakeholders. The curriculum was designed as a train the trainer model. Community mental health agencies may use the specific curriculum or substitute their own training if it covers the requirements in the Washington Revised Code:

- 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

LPRO staff received implementation information from Washington SEIU (1199nw). It was communicated that an ongoing barrier to full utilization among union members is that it is up to the employee to demand that a second processional be present, and that employee must also be willing to withhold care if one is not available. This was described as making the employee choose between safety and providing care. It was also shared that these community behavioral health organizations are under-staffed and so their members are limited in their ability to bring along a second, clinically-trained person.

The SEIU asked that we share a recent story where a behavioral health worker felt unsafe during a house visit where they were working alone. They had advocated for a second person with clinical training but the process was ongoing and has yet to be resolved so the employee has, in the meanwhile, continued to provide care alone despite feeling unsafe.

Task force members had the following discussion regarding lone worker policies:

- Chair Nelson asked for a gap analysis between Washington's SHB 1456 and existing Oregon policy.
    - Current Oregon policy applies primarily to the employment setting, rather than to the provider type as is the case with SHB 1456.
- Lankenau asked how SHB 1456 would fit with the peer model that Oregon crisis teams follow in the field.
    - SHB 1456 would presumably include peers as a second individual provided that the peer support worker has received the appropriate training.
    - This policy would presumably apply to Oregon community-based mobile crisis teams.
- Swanson asked which provider types were covered under SHB 1456 (types or responders, employers, and clients).
    - RCW 71.05.700 names DMHPs and "crisis intervention worker[s]"
    - The second individual may be a law enforcement officer, a mental health professional, a mental health paraprofessional who has received the training mandated in SHB 1456, or other first responder, such as fire or ambulance personnel. The second individual will be determined by the clinical team

supervisor, on-call supervisor, or individual professional acting alone based on a risk assessment for potential violence.
    - The law applies to clients at private locations, including home visits. SHB 1456 is focused on community mental health settings.

Informational Meeting:

Behavioral Health Care: Navigating Reimbursement and Staffing

Sam Byers, Adult Behavioral Health Director, Oregon Health Authority (OHA)

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

Chelsea Guest, CCO Finance Director (OHA)

(link to slides)

In prior meetings, members discussed how Medicaid reimbursements for behavioral health services relate to employers' staffing levels. Members requested additional information about how reimbursement levels are set for Oregon Health Plan (OHP).

Staff from Oregon Health Authority (OHA) provided a high-level overview of how reimbursement levels are established for providers serving OHP members and how these relate to state regulations for facility staffing levels.

Reimbursement Models in Behavioral Health

Oregon Health Plan members can be enrolled in a Coordinated Care Organization (CCO) for coverage or receive care that is directly reimbursed by OHA ("fee for service" or "open card" coverage).
OHA pays CCOs to provide coverage for behavioral health care to OHP members enrolled in a CCO. These payments occur three ways:

1. **Capitated per-member per-month (PMPM) payments** provide CCOs a "global budget" for all services required to be covered under OHP, including behavioral health services. Each CCO separately negotiates rates with providers in its network.
2. **Qualified directed payments** for behavioral health separately set a minimum payment level CCOs must pay outpatient behavioral health providers.
3. **Risk corridors,** which are temporary financial arrangements established when there is uncertainty about the potential costs or utilization for a new covered service. The risk corridor limits both potential losses or net income during a defined period and provides greater certainty to OHA and CCOs.

For OHP members with open card (non-CCO) coverage, OHA payments include:

- **Fee-for-service (FFS) payments** for outpatient behavioral health services. These rates have increased, in aggregate, by approximately 30% since July 2022 due to legislative investments. OHA also made two cost-of-living adjustments of 3.4 percent each in October 2023 and July 2024.
- **Tier-based rates** for residential services. These include care for people living in Home and Community-based Settings (HCBS) with mental health diagnoses or substance use disorders. OHA has made the same adjustments to these FFS rates that were made for outpatient settings (with the exception of adult foster homes and personal care attendant services that are collectively bargained).
- **Resource-Based Relative Value Scale (RBRVS),** a fee schedule for certain outpatient mental health services that are also covered by Medicare.

Certain behavioral health services are reimbursed by OHA under different payment methodologies than the ones described above. These other settings and payment models include:

- **Psychiatric residential treatment facilities (PRTF)** are reimbursed on a per diem basis. These rates were developed in 2022 through an independent rate study by an outside actuarial firm. This rate is updated every two years.
- **Mobile crisis intervention services (MCIS),** which include a higher rate for two-person teams that is intended to incentivize employers to avoid lone worker scenarios and reduce reliance on law enforcement.
- **Substance use disorder (SUD) services** are reimbursed under a value-based payment model that ties payments to patient outcomes. The fee schedule for this payment model is developed using American Society for Addiction Medicine criteria.
- **Inpatient psychiatric** stays are paid a base rate developed from modified Diagnosis-Related Groupings (DRG) with additional per diem amounts after 30 days.

Recent Agency Rate Studies

OHA provided additional details on reimbursement models for behavioral health providers (see below).

OHA recently contracted with Optumas, an actuarial firm, to complete a rate study for adult mental health residential services. This work involved outreach to providers through the Oregon Council for Behavioral Health and Association of Community Mental Health Programs to gather information the agency does not have access to through traditional claims and encounters data. Provider responses were lower than in prior years (a 53% response rate in 2024 versus 84% in 2019). Results from this study will be presented to OHA leadership in September to inform rate updates toward the end of 2024.

Provider	Payment Methodologies
Mobile Crisis Intervention Services	• **Standard** rate of $41.70 per 15 minutes • **Enhanced** rate of $112.87 for qualifying two-person teams where one person is a Qualified Mental Health Professional (QMHP) (OAR Chapter 309, Division 72)
Adult Foster Homes for Behavioral Health	• Collectively bargained every two years between SEIU and Oregon agencies • In 2023, bargaining resulted in increases of 5% (December 2023) and 4.5% (January 2025) • AFH representatives requested future OHA rate increases for HCBS providers include AFHs outside of the bargaining process
Personal Care Attendants	• Collectively bargained every two years between SEIU and Oregon agencies • Rates cover home care workers and personal support workers • In 2023, bargaining resulted in 1) a $1.73 per hour increase effective January 2024, and 2) effective July

	2024, a 5-step increase model based on a worker's hours and experience • The step increase model was applied retroactively for any hours worked after January 2023; a second step increase will be made in January 2025
Inpatient Psychiatric Services	• OHA engaged an actuarial firm, Optumas, to conduct a study of these rates in 2024 The review resulted in a significant increase for larger psychiatric hospitals; depending on acuity of the individual, new rates will be 1.5 to 2 times higher • CCO rates will be effective January 2025 and slightly later for OHP FFS
Children's Behavioral Health Continuum of Care	• OHA completed a rate study in 2022 that included PRTF, residential SUD, day treatment, in-home and rehabilitation services. • New rate study beginning late 2024 with recommendations by February 2025
OHP Fee-for-service	• OHA compared Medicaid and Medicare reimbursements in early 2024 • OHA's goal is to pay 80 percent of Medicare rates for Medicaid services, though most OHP behavioral health services are not covered by Medicare and cannot be benchmarked this way • A Medicaid state plan amendment (SPA) for these changes is under review by the Centers for Medicare and Medicaid Services
CCO Qualified Directed Payments for Behavioral Health	• Established through HB 5202 (2022) to ensure CCOs increase rates for behavioral health providers • Resulted in a ~30% increase for Medicaid providers in 2023-2024; a 10% increase will take effect in 2025 • Higher payments are available to organizations primarily serving Medicaid clients, providers of culturally and linguistically specific services, and those treating co-occurring disorders

<u>Linkages between Payments and Staffing Level Regulations</u>
OHA establishes minimum staffing requirements for behavioral health facilities that the agency licenses. They provided the following information about these staffing level requirements and acknowledged the importance of workforce development efforts and rate reviews in supporting safe staffing levels.

Provider Type	Maximum Capacity	Minimum Staffing
Mobile Crisis Intervention Services	NA	Incentive for two-person team to reduce reliance on lone workers and law enforcement
Adult Foster Homes	5 clients	1 worker at all times

Intensive Treatment Services*	None	Day shifts: 1 worker per 3 clients (1:3) Night shifts: 1:6
Regional Acute Care Psychiatric Services	16 (non-hospital clients)	2 at all times*
Residential Problem Gambling Treatment Programs	None	1 at all times
Residential Treatment Homes	5	1 at all times
Residential Treatment Facilities	16	1 at all times
Secure Residential Treatment Facilities	16	2 at all times*
SUD Treatment Facility	None	1 at all times*
Withdrawal Management Facility	None	1 at all times*

**additional professional staff requirements apply*

Task Force members discussed the need to consider how the state's minimum requirements for behavioral health staffing relate to current models for reimbursing care. OHA reviewed connection points between staffing regulations and provider payments.

Current areas where **staffing levels are directly influenced by payment mechanisms** include:

- **Documentation standards,** which apply to providers serving Medicaid clients when the client's receipt of services depends on a Level of Service Inventory (LSI) assessment.
- **Mobile crisis**, which includes an enhanced rate for two-person teams.
- **Adult foster homes**, where collective bargaining impacts the rates paid to providers and the staffing levels and wages providers can offer.
- **Personal care attendants**, where step-based increases impact staff wages, subject to collective bargaining.

In contrast, the following mechanisms to regulate staffing levels do not directly impact reimbursements:

- **Facility licensing and regulation**, which enforce staffing minimums but do not directly adjust payments.
- **Client care plans**, which can inform the staffing levels needed for a given client, but may not alter the payment a provider receives.

OHA operates a Rate Review Committee, a shared committee between its Medicaid and Behavioral Health divisions, to review requests for exceptions to their standard rates. This process is initiated by providers when the agency's client assessment tool does not adequately capture a client's service needs due to other factors such as risk of violence that require additional staffing supports.

The committee considers requests for more intensive services, provider retainer payments, or other funding needs to address medical complexity or forensic risks.

Opportunities for Collaboration

OHA highlighted areas where the Task Force and broader community can provide input to ensure rates support staffing needs:

- The agency continues to seek input on rate redesign as they work toward a new standardized payment methodology for residential behavioral health care for children and adults. The intent is to reduce reliance on rate exception requests for higher acuity clients and benchmark rates more strongly to Medicare where possible. Community input will inform the agency's CMS negotiations.
- OHA is working to implement new federal HCBS access rules by 2030, the federally required deadline. They are also implementing a new functional needs assessment tool to address known limitations of the LSI tool that does not adequately capture medical complexity or safety risks for clients with behavioral health conditions.
- OHA is piloting a questionnaire for hospital and CMHP staff to ensure clients are directed to the appropriate agency (OHA or ODHS) for needs assessments. This is intended to reduce duplication of assessment work, ensure timely completion of eligibility determinations, and improve referral timelines to HCBS.

Discussion

Chair Nelson asked whether hospitals with psychiatric units fall under the state's existing nurse staffing requirements for hospitals?

- OHA staff believe this falls under public health licensing regulations but will confirm and follow up.

Chair Nelson asked how Oregon's rates for behavioral health services compare to rates paid in Washington and California?

- OHA noted Medicaid services are defined and covered differently across states, making direct comparisons difficult. OHA reviews rates paid in Washington, California, Arizona, Nevada, and Michigan when updating its fee schedules because these states have similar population densities and mix of rural-urban areas to Oregon. Rates are generally competitive with these states.
- The addition of CCO directed payments for behavioral health has made Medicaid payments competitive with commercial rates for behavioral health services in Oregon. Medicaid also covers a wider range of behavioral health services than many commercial and Medicare Advantage plans.

Eric Sevos noted that the Task Force is contemplating policy changes to avoid lone workers, such as by raising the minimum staffing requirement to two in facilities where it is currently one. Has OHA studied the potential costs of these kind of staffing minimums as part of its rate review? If not, what process would be involved to do so?

- OHA would need to engage its actuarial firm, Optumas, to model the cost of these potential changes. This would require talking to providers to understand what costs would need to be considered because OHA is

not able to see all potential costs solely by reviewing claims and encounters data.
- When a case manager completes a person-centered service plan during a client's assessment process, they consider the staffing supports needed for a client's care. This step informs the reimbursement a provider receives for that client's care. This payment methodology is another place where reimbursements could be tied to higher staffing levels.

Devarshi Bajpai noted that outpatient mental health reimbursements do not account for variation in a client's acuity or complexity of care needs, or for differences in staffing costs for virtual versus office-based visits. Is OHA considering moving toward acuity based payments for outpatient mental health services?

- OHA's fee schedule does include some enhancements for clients with co-occurring disorders. This only applies to clients with fee-for-service (FFS) Medicaid coverage (not those enrolled in a CCO). OHA has not looked at acuity-based rates for these payments but could do so during its next rate review if recommended by the Task Force.
- Lack of accurate or complete data on client acuity can challenge their ability to implement acuity-based rates. Providers must collect and report this data which poses an administrative burden. OHA is moving toward an acuity-based approach for residential reimbursements. They will also offer an enhanced rate for some providers that are "primarily Medicaid serving" out of recognition that at the population level, Medicaid enrollees have higher acuity than other groups.

Sommer Wolcott asked how long the rate exception review process typically takes when a provider requests enhanced payment for a client with more intensive care needs? Who pays for additional staffing that may be needed for that client while the review is occurring?

- OHA has heard feedback that this process was too time consuming and has been working on this. Currently, more complex reviews are completed in approximately two weeks (these can involve reviewing hundreds of pages of documentation for a single client).
- Currently, providers absorb the cost of additional staffing that may be needed while the exception review is being conducted. OHA is piloting a new assessment tool that is intended to minimize the need for the exception review process by establishing these staffing needs up front during the initial assessment.

Stacy England appreciates that OHA has implemented the enhanced rate for two-person mobile crisis teams. However, claiming the enhanced rate requires having two staff for a 24-hour period. It would be helpful to move away from reimbursing mobile crisis on a fee-for-service basis toward a "firehouse model" that pays a retainer to maintain a team of a certain capacity at all times. Is OHA considering this approach?

- OHA noted the 24-hour rule is required to access the enhanced matching rate. Broadly, the agency intends for two-person teams to be the standard, but the rule also allows billing for a single provider out of acknowledgment of current workforce shortages. OHA is developing an emergency rule that will allow a qualifying two-person team to have a single person on the overnight shift while still being eligible for the

enhanced rate. This would be a temporary rule through July 1, 2025 to offer more time for mobile crisis organizations to transition to 24-hour two-person teams.

- OHA is working with the CCOs to move toward supporting two-person teams as the standard. They reported several CCOs are already paying for these services through alternative payment models though FFS remains common as well.
- OHA noted these are new payment models for the state and the agency is looking for how to make the two-person model financially sustainable for organizations over time. This includes evaluating the actual cost of operating these programs over time and developing the workforce for these programs.

Matt Swanson noted the Task Force is contemplating policy changes related to staffing levels, structural security, and safety plan requirements. Of these, it sounds like there are pathways to address enhanced staffing levels through Medicaid reimbursements on the FFS side, but new requirements related to structural security or safety plan requirements may need other funding mechanisms. Is this correct?

- OHA noted that Medicaid operates like an insurer but does include pathways for other types of investments. These require federal approval from CMS, which can occur through a Medicaid state plan amendment if the expenditure is something for which there is a strong evidence base, or through a Section 1115 demonstration waiver if the expenditure is a new approach that needs to be evaluated over time.

Members will continue the discussion on staffing levels and potential recommendations at the October 3rd meeting.

Public Comment	*None*
Meeting Materials	• *JTFBHS Post Meeting Summary - Meeting 3 - Aug 30 2024* • *JTFBHW Meeting #4 - LPRO (presentation)* • *JTFBHW Supplemental materials on safety plans and training requirements 8.30.24*