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Task Force on Improving the Safety of Behavioral Health Workers

October 3rd, 2024
Meeting #5: Staffing Levels (continued); Structural Security (new)

Roll Call

Please have camera on and microphone unmuted

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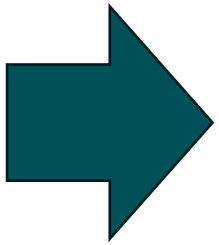
Workplan Progress

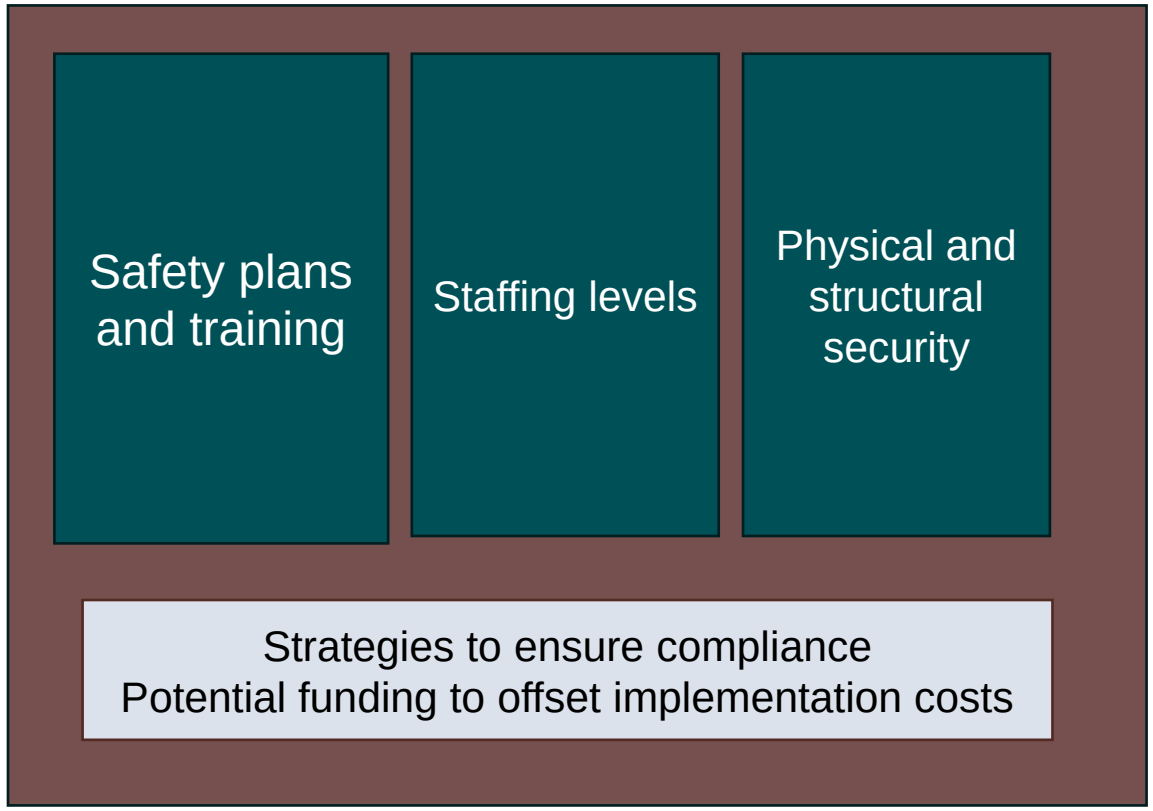
Draft Workplan	
Aug 7th	Scoping/Workplan
Aug 30th	Safety Plans
Sept 10th	Staffing Levels
Oct 3rd	Structural Security
Oct 18th	Draft Recommendations
Nov 7th	Draft Report
Nov 14th	Adopt Report



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?

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?

Workplan Progress



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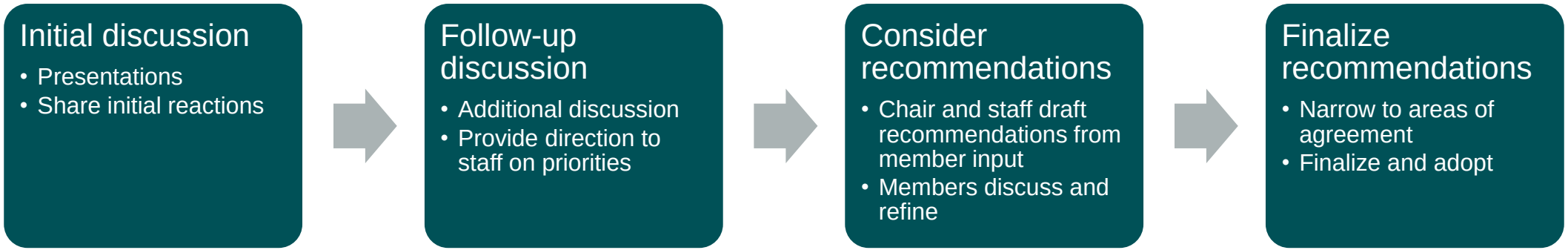
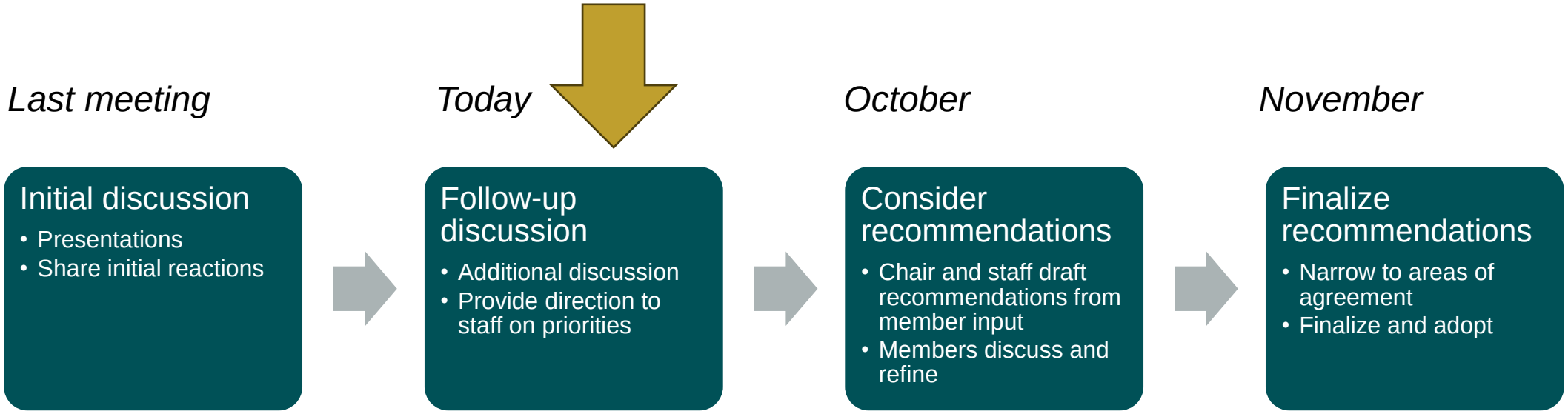
Getting to recommendations

*Within each of the 3 policy domains:**

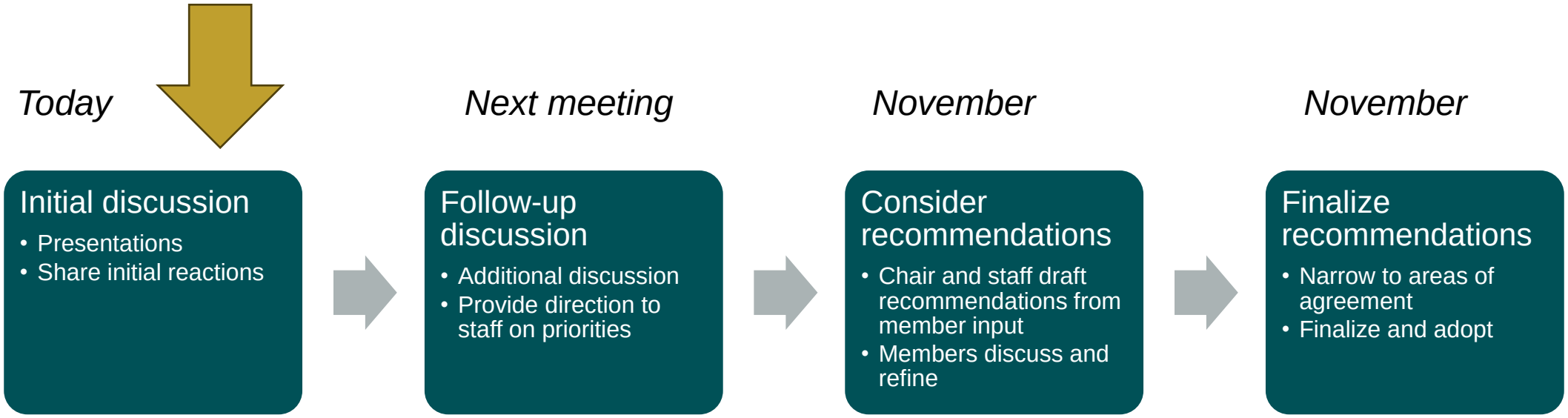


** 1) Safety plans, 2) staffing levels, and 3) physical/structural security*

Staffing Levels (Topic 2 of 3)



Structural Security (Topic 3 of 3)



Agenda for Today

October 3rd, 2024

- Discuss member priorities for staffing levels
- Overview of physical and structural security best practices
- Oregon’s Home and Community-based Services Regulations

Discussion: Member Priorities for Safe Staffing Levels

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Recap: Lone Worker Policies

Lone Workers

- Any employee in a situation or location without a colleague nearby or working without supervision
- Increased risk of experiencing violence and with more severe outcomes

Lone Worker Policies

- Address the need to assess risks, develop communication systems, and train staff
- In the U.S., more common in other industries than health care

Example: “Marty Smith Law” (WA) addresses lone workers in behavioral health

- Crisis workers cannot be required to respond alone to unsafe situations (based on their clinical judgment)
- Requires employers to have a written policy, annual worker training
- Requires employers to provide wireless communication devices and prompt access to patient histories
- Washington labor reps note staff can still feel they need to choose between working alone or withholding needed patient care

Recap: Oregon Health Authority Reimbursement Models

- **Oregon Health Plan (OHP) coverage with a Coordinated Care Organization (CCO)**
    - Oregon Health Authority (OHA) pays CCOs a “global budget” (PMPM) for all enrollees; CCOs negotiate rates with providers in their networks
    - OHA makes additional “directed payments” to raise CCO behavioral health payments
- **Oregon Health Plan coverage with Oregon Health Authority (fee for service/open card)**
    - Follows a fee schedule for outpatient behavioral health services
- **Other payment models vary**
    - Home- and community-based services (HCBS) (tiered rates)
    - Mobile crisis intervention services (MCIS) (rates for one- and two-person teams)
    - Substance Use Disorder (SUD) services (value-based payment model)
    - Inpatient psychiatric stays (case rate based on diagnosis-related group)
    - Psychiatric residential treatment facilities (per diem basis)

Recap: OHA Staffing Regulations

- **Minimum staffing requirements** generally tied to facility licensing, not payment
    - Most OHA licensed/regulated behavioral health facilities = minimum 1 worker (includes adult foster homes, residential treatment homes and facilities, SUD treatment and withdrawal management facilities, problem gambling facilities)
    - Regional acute care psychiatric and secure residential treatment facilities = minimum 2 workers
    - Intensive treatment services = staff-to-client ratios for day and night shifts
- **Client care plans** can indirectly inform staffing needs for a given client
    - Care plans do not directly determine payment level; provider can request a rate exception (~2 weeks)
    - OHA piloting new client assessment tool to minimize need for rate exceptions
- Some payment models directly influence **staffing/wages**
    - Personal care workers (stepped increases)
    - Mobile crisis (enhanced rate for two-person team)

Recap: Linking Staffing Levels to Payments

- OHA rate studies periodically conducted to update payment models
    - Cycle varies by service type (often two-year cycle)
    - Rate studies engage providers and workers to collect information about needs and costs
    - Rate recommendations developed by independent actuaries
- Future rate studies could include consideration of new safety costs, with provider input
    - Avoiding lone workers
    - Adjustments for client acuity
    - Other employer costs like structural safety elements
- Changes could require federal negotiations

Next Steps

Staffing Levels

- Any new reflections on **safe staffing levels***
- 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 discussed separately

Next Steps: Issues and Ideas

Issue	What would help?
Workers may be asked to work alone in situations that present safety risks. Oregon has **limited lone worker protections** that apply to home health, home care, and hospital workers. Other behavioral health (BH) workers are not covered (other than by a general right-to-refuse work in unsafe situations). Employers are not currently required to provide additional staff or communication technology (panic buttons, etc.) to lone workers in most BH settings.	• Require BH employers to have a plan for lone worker scenarios and related trainings? • Require BH employers to offer certain technological supports (such as communication devices) to lone workers?
The **minimum staffing requirement** in many residential and community-based BH settings is for a single worker. Current Medicaid reimbursements would not cover costs of higher minimum staffing requirements. The cost impact to employers is unknown.	• OHA could engage an actuary to model the cost to raise the minimum staffing requirement for BH facilities to no less than two workers. • This cost information could inform the agency's next cycle of rate updates for BH providers.

Next Steps: Issues and Ideas

Issue	What would help?
OHA's fee-for-service reimbursements for outpatient mental health, SUD, and residential care are not **adjusted for client acuity** or additional staffing needs required in a client service plan. The process to request a rate exception can take 2 weeks and providers absorb the cost of additional staff during these periods.	• Develop residential and outpatient BH payment models that are tier-based and adjusted for a client's acuity and person-centered service plan. • Minimize reliance on rate exception requests and minimize the time to request an exception.
The current **payment methodology for mobile crisis** intervention teams is a fee-for-service (FFS) approach that does not cover the cost of maintaining two-person teams at all times over a 24-hour period.	• Update Medicaid payment methodologies -- including 1) OHA fee schedules and 2) CCO payment models -- to transition payments for mobile crisis services from FFS reimbursement to a retainer-based approach that pays for capacity.
OHA's Medicaid rate redesign process, currently underway, may not capture **employers' costs to implement** new structural security elements or safety planning policies. It is unclear whether Medicaid could pay for these costs through other channels than FFS provider reimbursements.	• Engage Optumas or other actuary to model the cost of structural security elements or safety planning policies recommended by the Task Force. • Study potential pathways to access Medicaid funding for these recommended supports, and the federal approvals that would be required. • Report findings to the legislative assembly, including resources and state/federal approvals needed, by [date].

Discussion

Safety Plans and Trainings

With regard to **safe staffing levels**:

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: Physical and Structural Security

Domain 3

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What we heard from you so far re: physical and structural security

Needs and Opportunities

- Systems for monitoring staff safety (communication devices, panic buttons, cameras)
- Structural elements (furniture, windows, doors, locks)
- Layout of buildings or settings (sight lines, escape routes, barriers)

Implementation Considerations

- Current state of facilities
    - Not purpose-built, or built for different acuity level than today's needs
    - Older buildings; deferred maintenance
- Limits on what can be changed in rented/leased spaces
- Some needs are specific to certain facility types (e.g., mobile crisis or state hospital)
- Remodeling can be expensive, may worsen access issues

Data insights: Workers Compensation

DCBS analysis of **2,126 workers compensation claims for violence against behavioral health workers** (2013-2022)

- 85% of qualifying claims occurred in two setting types (n=1,809)
    - Residential care facilities (IDD, mental health, SUD) (1,079)
    - Psychiatric and SUD hospitals (n=730)
    - Claims in other settings were relatively less common
- 88% of claims resulted from hitting, kicking, beating, shoving (n=1,873)
- 97% of claims did *not* involve a weapon or secondary object
    - When a secondary object is involved, it is typically a chair (n=11)

The Oregon Department of Consumer and Business Services reviewed workers compensation claims involving workplace violence during 2013-2022. The analysis focused on behavioral health workers and those who work in behavioral health settings who were identified using Standard Occupation Codes (SOC) and North American Industry Classification System (NAICS) industry codes. The analysis identified 2,126 of these claims that were accepted by the insurer because the injured worker missed three or more days of work. Claims where the injured worker did not miss work are not required to be reported and are not reflected in the analysis.

See Task Force meeting materials from October 3rd 2024 for memorandum from DCBS with complete analysis.
https://olis.oregonlegislature.gov/liz/2023I1/Committees/JTFBHW/2024-10-03-13-00/MeetingMaterials

Structural Security in Residential Behavioral Health Care

Facility Guidelines Institute

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Home and Community-based Care Regulations

Oregon Department of Human Services

Oregon Health Authority

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Discussion

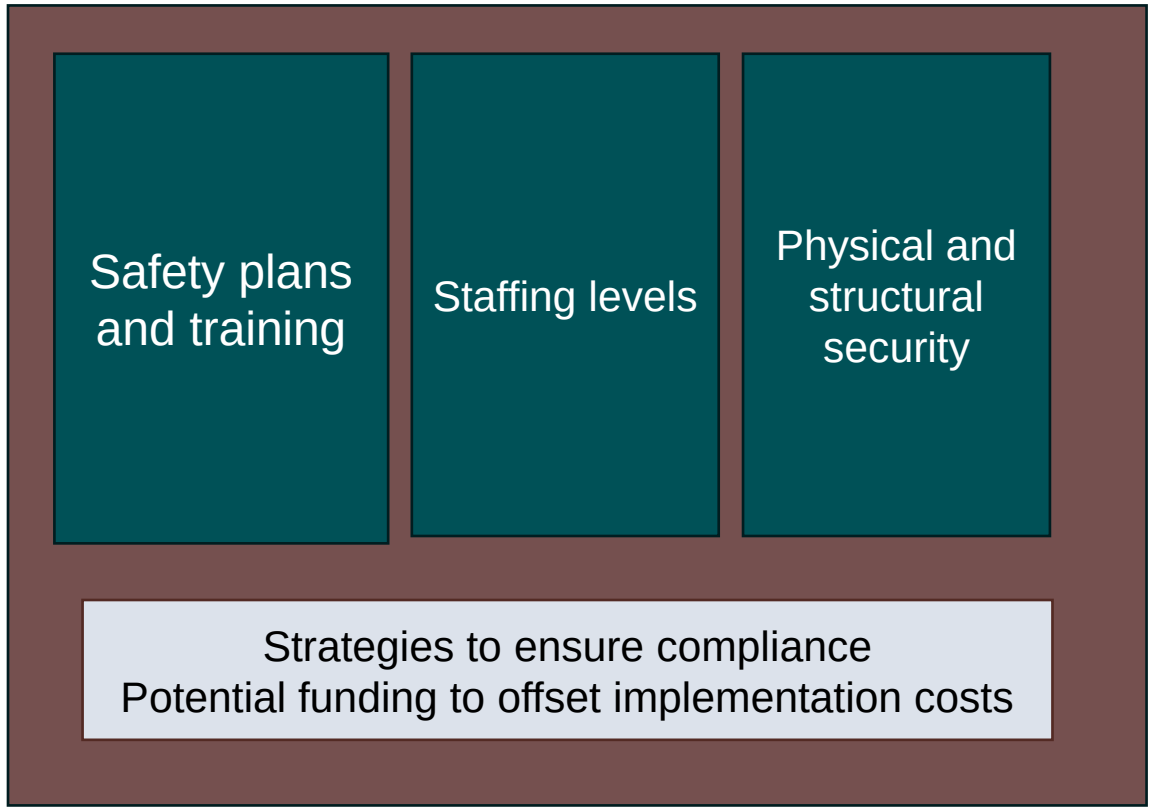
Staffing Levels

What are the biggest barriers to improving physical/structural security in behavioral health settings?

Are challenges similar or different for residential and outpatient settings?

What would help address these challenges?

Workplan: Coming Up



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Getting to final report

Next meeting

Consider recommendations

- Review first draft of recommendations based on member input to date
- Members review and discuss

November 7th

Finalize recommendations

- Review revisions
- Narrow to areas of agreement
- Review and discuss draft report

November 14th

Finalize report

- Review revisions
- Adopt