Meeting Summary

Joint Task Force on Improving the Safety of Behavioral Health Workers

Meeting #5

Link to Task Force on OLIS

LPRO LEGISLATIVE POLICY AND RESEARCH OFFICE

Date/Time	October 3, 2024 (link to recording)
Attendees	Rep. Travis Nelson, Chair Devarshi Baipai Clay Cruden Stacy England Linda Patterson Anna Peña Eric Sevos Penny Wolf-McCormick Excused: Rep. Cyrus Javadi, Sen. Lynn Findley, Sen. Chris Gorsek, Ryan Bell, Dave Boyer, Jeremy Lankenau, Alexander Mackaben, Matt Swanson, Sommer Wolcott
Review of workplan and agenda	LPRO staff reviewed the agenda for the meeting and workplan. In addition, reviewed the process that the Task Force will utilize to develop and approve their recommendations.
Informational Meeting: Overview and Discussion: Member Priorities for Safe Staffing Levels Rep. Travis Nelson, Chair (LPRO staff slides)	LPRO staff provided a recap of key points from September 10th presentations on lone worker policies, Oregon Health Authority (OHA) reimbursement models, OHA staffing regulations, and linking staffing levels to payments. Chair Nelson led the Task Force in a discussion of Task Force member priorities for safe staffing levels. 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. Task Force Members reviewed the issues and ideas in the table in staff slides (see slides 14-17) and shared the following points on table contents.

Issue: Lone Worker Protections	
Behavioral health (BH) 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 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.	
What would help?	**Member discussion**

Require BH employers to have a plan for lone worker scenarios and related trainings?	Cruden asked whether employers are required to communicate that staff are allowed to refuse work in unsafe environments. Chair Nelson indicated an interest in creating such a requirement and in posting lone worker policies in public settings for ease of access. Peña agreed and noted the importance of having policies written down and accessible. Cruden shared that workers likely do not have access to training to know their existing rights.
Require BH employers to offer certain technological supports (such as communication devices) to lone workers?	Bajpai asked how lone workers are defined in state law and noted this would be an important consideration. Staff noted there does not appear to be a formal definition in state law; ORS 654 refers to protections for workers in certain settings who are allowed to refuse work or request the presence of a second worker if they are concerned about the risk of an assault. Sevos indicated those measures and having a written plan requirement seem reasonable. Communication devices are important as well though depending on setting, technologies like monitored camera feeds or fobs for keyless entry could be more effective. Lone worker status can be transient depending on where someone is located in a building, etc. Pena was interested in a recommendation that workers could request a second worker before performing certain duties, as well as requirement to provide fobs, upgrade lighting, etc. England noted the Task Force could suggest a list of things an employer plan should address, since it may vary by setting.

Issue: Minimum Staffing Requirements

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.

What would help?	Member discussion
OHA could engage an actuary to model the cost to raise the minimum staffing requirement for BH	England added that the workforce shortage is a consideration, asking what happens if an agency does not have sufficient staff to follow minimum staffing requirements. Is the facility required to shut down? Sevos acknowledged that this is an issue and noted that in some areas they contract with other agencies and/or bring in a supervisor to cover a shift or keep staff on shift

facilities to no less than two workers. This cost information could inform the agency's next cycle of rate updates for BH providers.	for additional hours. Cruden noted that there is no one-size-fits all solution with minimum staffing levels, suggesting that a staff waiver system could be an approach with lone worker protections to support staff. Bajpai asked whether a minimum staffing requirement could result in requiring staff to work additional shifts when another employee is unavailable, even if there are no apparent safety risks. Sevos noted that this does happen. Chair Nelson asked whether employers should be required to offer additional de-escalation or self-defense training as a potential approach to working around minimum staffing levels. Peña noted de-escalation training should be happening during onboarding and not after an incident. It can be helpful when agencies bring in contract workers to fill emergency shortages, but these workers also need to be trained. England agreed that both de-escalation and self-defense training are needed, noting trainings do not always include spatial awareness training. Patterson added that teams can employ huddles at shift changes where employees receive updates on client/patient status before reporting for work. Sevos agreed and added that employees being trained in risk assessment and protocols are important to support this.

Issue: Fee-For-Service and Client Acuity

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.

What would help?	Member discussion
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	Sevos noted that residential rates are already tier-based and somewhat adjusted for acuity. The challenge is that when patient acuity rapidly escalates, it takes too long to negotiate a rate exception. Bajpai noted that unlike residential rates, outpatient mental health reimbursements from CCOs are usually case rates based on diagnosis. These payments are not adjusted for acuity which is challenging when providers need higher staffing levels for certain clients.

requests and minimize the time to request an exception.

Issue: Mobile Crisis Payment Methodology
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.

What would help?	Member discussion
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.	Sevos noted payment models for mobile crisis services vary by region and payer. England said that metro area CCOs have adopted a prospective payment model for two-person mobile crisis teams, where the provider reports on encounters after receiving the up-front payment. A risk corridor financially protects both the provider and CCO. This approach has been helpful but other CCOs are still r eimbursing for mobile crisis on a fee for service basis. Bajpai agreed it would be helpful if all CCOs adopted the approach used in the metro area. Sevos noted the importance of counties also moving to a prospective payment model that covers two person teams. Not everyone is enrolled in Medicaid. County contracts for mobile crisis cover the gap. England noted that counties such as Multnomah receive mobile crisis funding from the state and may subcontract with local providers. There can be information sharing agreements in place with CCOs.

Issue: Rate Design Process
OHA's Medicaid rate setting processes 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.

What would help?	Member discussion
Engage Optumas or other actuary to model the cost of structural security elements or safety planning policies	Sevos supports the state studying how Medicaid rates could be leveraged to cover these costs. He suggested the state should also separately invest general fund dollars to support safety enhancements because Medicaid will not address everything. Investments need to cover costs up front, not retroactively.

	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].	Bajpai also supports actuarial analysis and agreed with Sevos regarding the state needing separate general fund investments for safety enhancements.

Informational Meeting:

Physical and Structural Security in Behavioral Health Settings

LPRO Staff

LPRO staff provided a review of findings from the Task Force Needs Assessment Task Force specific to physical and structural security. Key points from the presentation included:

- The survey completed by Task Force members identified three aspects of structural security to consider: 1) technological infrastructure for monitoring and communication, 2) structural elements such as furniture and hardware, and 3) the physical layout of settings.
- Factors that may impact providers' ability to implement structural changes include the age and condition of existing facilities, whether they are owned or leased, or whether the facility can be taken offline for remodeling.

Staff also presented highlights from an analysis of workers compensation claims conducted by the Oregon Department of Consumer and Business Services (DCBS). DCBS analyzed 2,126 workers compensation (WC) claims between 2013-2022 involving an incident of violence against a behavioral health worker that resulted in three or more days of missed work. Key findings include:

- 85% of these claims occurred in two types of settings: 1) residential care and nursing facilities (n=1,079), and 2) psychiatric and substance use disorder hospitals (n=730). Claims in other settings, including outpatient mental health and emergency shelters, were present in the data but relatively rare compared to these other setting types.
- 88% of these assaults involved hitting, kicking, beating, or shoving (n=1,873). The use of a secondary object as a weapon was rare; only 3% of claims included a secondary object, and the most common object was a chair (n=11).

These data should be interpreted as a snapshot of the most severe incidents but not a complete picture of workplace violence in behavioral health settings. These claims reflect incidents where a worker is injured enough to miss three or more days of work and file a

claim. Most incidents of workplace violence do not rise to this level of severity or are not reported for other reasons.

A supplemental memorandum is available on OLIS.

Informational Meeting:

Physical and Structural Security in Behavioral Health Settings

Structural Security in Residential Behavioral Health Care - Facility Guidelines Institute

Kimberly N. McMurray, AIA, NCARB, EDAC, MBA, Principal, BHFC Design

John Williams, Vice President, Content and Outreach, Facility Guidelines Institute

Jonathan Westall, FACHE, CPP, VP Ancillary and Support Services, MLK Community Healthcare

(link to slides)

Facility Guidelines Institute (FGI)

- FGI is a nonprofit code writing organization focused on minimum standards for medical residential facilities.
- FGI authors several standards which take a risk-based approach and are scalable based on risk-level within a facility, covering new work (e.g. new buildings/facilities and renovation of existing facilities).
- Generally, FGI approaches building safety in two primary ways: 1) building codes and 2) state-specific licensing/certification guidelines, based on building purpose.
- FGI authors three volumes of guidelines, each specific to a different type of setting:
    - **Hospitals** (institutional and emergency settings)
    - **Outpatient** (behavioral health crisis units, freestanding behavioral health clinics)
    - **Residential facilities** (full spectrum of settings/facilities, considers size of facility)
- Codes are revised every four years based on multidisciplinary input and risk assessment.
- 43 states (including Oregon) have adopted some edition of the FGI Guidelines.

Additional safety-focused resources are available from the International Association for Healthcare Security and Safety Foundation (IAHSS), including: Security Design Guidelines for Healthcare Facilities, Healthcare Security Industry Guidelines, Evidence Based Healthcare Security Research Series, and Workplace Violence Prevention Certificate Program.

Behavioral Health Design Guide *(2022 edition available on OLIS)**:***

- A guidance document for staff safety in facility design
- Utilizes *Environmental Safety Risk Assessment Methodology*
    - A tool for considering elements of risk in structural design.
    - Conceptualizes risk assessment in five levels (I-V) based on perception of patient intent and opportunity for self-harm. Levels consider location of staff and patients and opportunities for interaction.
- FGI Guidelines correspond to risk levels outlined in methodology.

Task Force Members asked questions after the presentation as follows:

- Sevos asked about whether the guidelines include considerations for weapons screening based on risk level. IAHSS offers some resources on this topic. California has a current bill (Assembly Bill 2975) related to weapons screening. FGI Guidelines do not explicitly include weapons screening but leave room for consideration based on risk assessment level.
- Chair Nelson inquired about resources required to implement weapons screening in CA hospitals and other lessons. Additional staff were required. Westall noted the need to emphasize safety and security through operations as opposed to "building a fortress." AB 2975 was described as an unfunded mandate.
- England brought up the tension between security and respect for individuals, noting challenges in implementing weapons screening in some areas of the state and concerns about stigmatization and staff safety concerns. She asked whether this kind of screening could be implemented in a trauma-informed manner. Westall noted more covert screening technology is available and screenings can be done in private

settings. McMurray noted Oklahoma has had success with multiple screening locations in facilities.

Chair Nelson invited presenters to share information about preferred brands for physical safety technology with the Task Force.

Informational Meeting:

Physical and Structural Security in Behavioral Health Settings

Home and Community-Based Care Services Regulations

Jane-Ellen Weidanz, Deputy Director of Policy, Aging & People with Disabilities, DHS

Connie Rush, Mental Health Licensing & Certification Manager, Oregon Health Authority (OHA)

Shannon Myrick, Chief of Staff, ODD

(link to slides)

Staff from Oregon Department of Human Services (ODHS) and Oregon Health Authority (OHA) provided an overview of Oregon's regulation of home and community-based settings as it pertains to provider options for safety enhancements.

Home Like Settings are **not** defined in Oregon Revised Statutes (ORS) or Code of Federal Regulations (CFR) but in administrative rules.

Facility	Definition
Adult Foster Homes (AFH) serving 5 or fewer residents per facility	OHA, ODHS Aging and People with Disabilities (APD) and Office of Developmental Disabilities Services (ODDS) define home-like setting as: *an environment that promotes dignity, security and comfort of individuals/residents through the provision of personalized care and services and encourages independence, choice, and decision making for the individual.*
Assisted Living Facility (ALF) and Residential Care Facility (RCF) usually serving 6 or more residents per facility.	APD's Assisted Living Facility (ALF) and Residential Care Facility (RCF) definition of a "home like environment" is *a living environment that creates an atmosphere supportive of a resident's preferred lifestyle, supported by building materials and furnishings*.

Home and Community Based Setting Regulations

- Home and community-based services (HCBS), including AFHs, ALFs, group homes, RCFs, and Residential Treatment Homes and Facilities, are funded through Medicaid for all 3 programs (OHA, APD, and ODDS).
    - Must adhere to federal regulations (CFRs) surrounding individual rights;
    - State licensing, adult protective service statutes, and administrative rules also apply to these settings.
- Settings must:
    - Be integrated into the community and support individual access;
    - Ensure individual rights to privacy, dignity, respect, and freedom from coercion and restraint; and
    - Optimize autonomy, initiative, self-direction, and independence in making life choices.
- Individuals have the right to: choose their preferred setting, have a Residency Agreement with the same eviction protections as Oregon landlord tenant law, have privacy within their unit via lockable doors with only appropriate staff access, choose their roommate in shared rooms, decorate/furnish their unit within the Residency Agreement, have visitors at any time, control their own schedule/activities, and access food at any time.
- **Individually-Based Limitations (IBL)** (federally known as Modifications to Conditions)

- May be requested where an individual living in in a HCBS setting cannot safely manage the resident rights specified in state/federal regulations.
- IBL are a "last resort" and must be agreed to by the individual/guardian, be the minimum necessary to protect the individual or others, include assurances that the intervention does not cause harm to the individual, be approved by a case manager as appropriate, and be time limited.
- An individual who consents to IBLs can revoke consent at any time.

The agencies provided an overview of how restraint of an individual in a BH setting can be considered abuse, which varies by program.

System	Definition of Abuse	Use of Restraints
APD system - Adults	*The wrongful use of a physical or chemical restraint of an adult is considered abuse*. Wrongful use of restraint refers to situations where: • A licensed health professional has not conducted a thorough assessment prior to implementing a licensed physician's prescription for restraint; • Less restrictive alternatives have not first been considered; • The restraint is used for convenience or discipline.	• Physical restraints may be used in licensed and certified Secure Residential Treatment Facilities (class 1 facilities), Secure Transport companies when necessary to prevent injury to individual or another person, only allowed as a last resort. • Must be initiated by a licensed and independent practitioner, physician assistant/associate, or registered nurse. • Emergency restraints may be used by other facilities to prevent immediate injury to an individual after other interventions have been attempted. Individuals must be evaluated at a hospital following the use of emergency restraints.
ODDS system - Adults	*The wrongful use of a physical or chemical restraint upon an adult is considered abuse.* Excluding the act of restraint consistent with an improved treatment plan or in connection with a court order. Within the Developmental Disability (DD) system, functional behavior assessments are used to develop Positive Behavior Support Plans (PBSPs). PBSPs can include restraints as an emergency crisis strategy.	• Use of restraints for **children** in DD group/host/foster homes are only permitted if behavior poses a reasonable risk of imminent serious bodily injury to the child or others, only when less restrictive interventions would be ineffective. • Restraints are written into PBSPs for both adults/children and are consented to via IBL. • Emergency restraints are only permitted outside of a PBSP where an imminent risk of harm exists or where **adult** behavior could lead to engagement with legal/justice system, only as a last resort for as long as the imminent danger is present.

		• All individuals who may apply restraints must be trained.
Children's Behavioral Health	ORS 418, abuse for children in care includes the wrongful use of restraints and involuntary seclusion. Emergency restrains are allowed in limited circumstances only, otherwise must be authorized via written order and monitored by a licensed professional: • Medical professional, Qualified Mental Health Professional (QMHP), or a Children's Emergency Safety and Intervention Specialist (CESIS) – professionals licensed in restraint use for specific population	• Supine restraints permitted only in licensed secure inpatient programs (child and adolescent) only as a last resort by a qualified professional. • Physical restraint or seclusion may be used in other settings only in emergency situations. • Restraints and seclusion may not be used simultaneously. • Special training is required for those applying restraints to children.

Chemical restraints are unauthorized in community-based settings. Restraints may not be used as punishments for behavior, for staff/facility convenience, or to offset staffing shortages within a facility. Improper/unauthorized use of restraints is considered abuse. The ODDS system for children/adults specifically prohibits use of restraints that are: retaliatory, chemical, mechanical, prone, supine, or lateral.

Perspective on OSHA Recommendations and Safety Installations

ODHS and OHA provided input on which of the approaches commonly suggested by OSHA for workplace safety are permissible under HCBS facility licensing requirements in Oregon.

Under current rules, HCBS facilities may:

- Provide staff with panic buttons, GPS tracking, cell phones.
- Offer a safe room, locked restrooms for staff in residential settings (though not in AFHs), provide comfortable sitting/waiting areas.
- Staff for the level of acuity for the individuals being served and to avoid staff turnover.
- Change/add materials to reduce noise.

Under current rules, facilities likely cannot:

- Require a second exit within the resident's room.
- Lock unused doors to limit access to spaces (this may be permitted with closets and storage).
- Secure furniture in individual rooms.

Under current rules, facilities cannot:

- Arrange furniture so that staff have clear exits within individual units.
- Require weapons screening via metal detector (though this may be possible for visitors).

The following safety installations are or are not allowable under HCBS rules:

- Allowable:
  - Door locks on staff offices.
  - Alarms on doors/windows in common areas.
  - Intervention training for all staff.
- Prohibited:
  - Door locks on private rooms that would seclude a resident.
  - Use of unauthorized restraints.
  - Metal detectors and private room searches.
  - Video monitoring in personal areas and other places where care might occur.
  - Securing furniture to the floor/wall.

Task Force Members asked questions after the presentation as follows:

- Sevos noted ongoing issues related to staff safety and HCBS rules for high acuity clients, and asked if it would be possible to create rules for new types of facilities that better prioritize staff safety (e.g. limiting visitation) while still allowing for Medicaid system funding. Weidanz acknowledged that the level of patient complexity can be difficult to navigate, however this may require renegotiating federal waivers (when there is no indication this would be approved at the federal level) or pursuing a fully state-funded program that foregoes federal match. This would likely be cost-prohibitive.
- Chair Nelson asked how widespread the use of panic buttons are currently in Oregon and whether any programs require them. The agencies replied none of the current programs require panic buttons in residential settings. New recommendations that require residential facilities to install safety technology like panic buttons would likely be challenging for HCBS settings as these are small facilities. Cruden brought up importance of ease and speed of access for staff to safe rooms and the utility of key fobs or biometric door controls in these spaces.
- Chair Nelson also inquired about requirements within building codes and how to increase security within newly built facilities. This can be challenging in home-like settings as facilities are commonly renovated homes that were built to different code expectations than purpose-built facilities. Sevos noted new state appropriations have been made for BH sector capacity building and may present an opportunity to include safety requirements within facility design. It was suggested that the inclusion of specific safety requirements be considered when creating new funding opportunities for facilities. Connie Rush agreed that this was a beneficial approach and said that they would bring the suggestion back to the relevant OHA group.

Informational Meeting:

Physical and Structural Security in Behavioral Health Settings

Chair Nelson asked for discussion among Task Force members regarding physical and structural security, specifically where members saw the biggest barriers to improving security in behavioral health settings, whether challenges were similar/different for residential and outpatient settings, and how challenges could be addressed.

Task Force members had the following discussion:

- Sevos noted that increased financial resources would help providers expand provisions to support physical and structural safety, such as installing fob access across buildings.

Rep. Travis Nelson, Chair	○ Bajpai noted the existence of barriers to safety within existing infrastructure but agreed that a lack of financial resources is the greatest barrier to addressing physical/structural security in behavioral health settings. ○ England added that a challenge is the tension between patient/client rights and worker rights. For example, tension for crisis workers to not respond with law in potentially dangerous situations. While residents should be permitted to have visitors, allowing visitors 24 hours in group settings can potentially increase risk for crisis workers. Putting structural safety elements in place can be challenging if those practices/elements are not seen as client-centered. ○ Cruden noted that guidelines for small community-based services are limited, having basic safety requirements that extend beyond what a standard employer would offer could be helpful in standardizing safety practices across facilities. ○ Bajpai added it is important to think about the trade off between making an environment trauma-informed and client-friendly while also including structural and physical safety components.
Public Comment	*None*
Meeting Materials	• *JTFBHS Post Meeting Summary - Meeting 4 – Sept 10 2024* • *JTFBHW Meeting #5 - LPRO (presentation)* • *2022 Edition Behavioral Health Design (guide) - Kimberly N. McMurray* • *JTFBHW Supplemental materials on Worker's Compensation Violent Claims Data Department of Consumer Business Services (memorandum) 2024*