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Task Force on Improving the Safety of Behavioral Health Workers

October 18, 2024
Meeting #6: Structural Security (continued); Draft Recommendations

Roll Call

Please have camera on and microphone unmuted

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Workplan and Agenda

LPRO Staff

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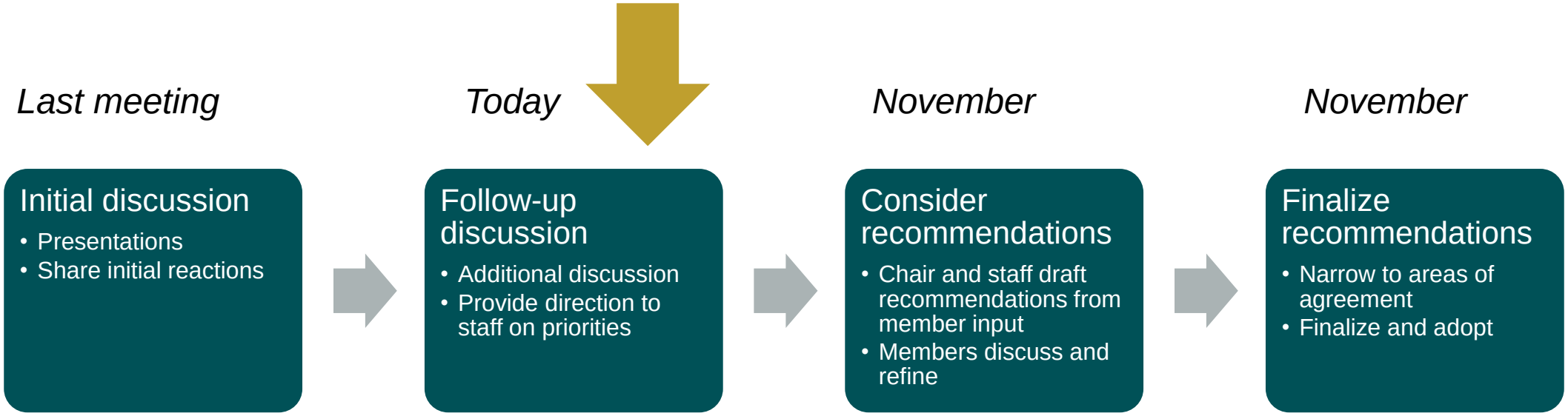
Structural Security (Topic 3 of 3)



All Topics

Prior Meetings | *Today* | *November*

Initial discussion
- Presentations
- Share initial reactions

Follow-up discussion
- Additional discussion
- Provide direction to staff on priorities

Consider recommendations
- Chair and staff draft recommendations from member input
- Members discuss and refine

Finalize recommendations
- Narrow to areas of agreement
- Finalize and adopt

Agenda for Today

October 18, 2024

- Discuss member priorities for structural security (follow-up)
- Review list of potential policy concepts
- Discuss recommendations

Priorities for Physical and Structural Security

Chair Nelson and LPRO Staff

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Recap: DCBS Data and FGI Insights

DCBS analysis[1] of 2,126 workers compensation claims for violence against behavioral health workers (2013-2022)

- 85% of qualifying claims occurred in residential care facilities and psychiatric/SUD hospitals
- 88% of claims resulted from hitting, kicking, beating, shoving (n=1,873)
- 97% of claims did *not* involve a weapon or secondary object

Insights from Facilities Guidelines Institute (FGI)

- Nonprofit code writing organization focused on minimum standards for medical residential facilities
- Authors structural safety guidelines for medical residential facilities: **hospitals, outpatient, and residential**
- Authors the Behavioral Health Design Guide with guidance for staff safety
    - Follows Environmental Safety Risk Assessment Methodology for evaluating risk in structural design

1. Vawter, E. "Workers Compensation violent claims data for behavioral healthcare workers" (memorandum). September 11, 2024 (rev. September 24, 2024).Oregon Department of Consumer and Business Services. Available at https://apps.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/286287

Recap: Oregon's HCBS Waiver Connections

Home and Community Based Services (HCBS) Settings

- Adult Foster Homes, Assisted Living Facilities, Residential Care Facilities
- Must adhere to federal regulations, state licensing and regulations regarding client rights

Perspective on OSHA Recommendations

- Facilities may: Provide panic buttons, GPS tracking, and cell phones; offer a saferoom and locking restrooms in some settings; change materials for noise reduction, and staff for the level of acuity
- Facilities likely cannot: require a second exit in private units, lock doors to limit access, secure furniture in private units
- Facilities cannot: arrange furniture in private units to create clear exits, require weapons screening for residents

Perspective on Safety Installations

- Allowable: door locks (staff offices), alarms on doors/windows in common areas, staff intervention training
- Prohibited: door locks (private units), unauthorized restraints, metal detectors, private unit searches, video surveillance in places where care might occur, securing furniture

Next Steps

Physical and Structural Security

Any new reflections on **structural security**

Review first draft of concepts

Discuss your priorities for recommendations

Next Steps: Issues and Ideas

Issue	What would help?
Facilities vary widely in terms of their built environment and options to enhance structural security. Groups such as FGI suggest facilities need to assess the security risks and opportunities in their specific context. Behavioral health facilities are not currently required to have a written safety plan that includes an assessment of the built environment.	As part of a written safety plan, behavioral health employers should be required to assess the built environment and how it may support or impede self-defense by a worker who is being assaulted. Suggested components of the assessment include: *[TF members to add suggestions?]*
Existing behavioral health facilities often lack elements such as keyless entries or panic buttons that would support staff during incidents of violence. Employers do not have a source of revenue to cover the cost to retrofit facilities with these safety enhancements.	The legislative assembly should appropriate general funds and direct [OHA?] to offer grants to behavioral health providers to retrofit existing facilities with safety enhancements such as keyless entries (e.g. fobs or biometric scanners) and panic buttons.
The state does not currently require that new behavioral health facilities include elements such as keyless entry or panic buttons in the facility's design as a condition to receive public funds.	The legislative assembly should require that any newly constructed behavioral health facilities receiving state funding must include elements to enhance worker safety in the facility's design.

Discussion

Physical and Structural Security

With regard to **structural security**:

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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Considering Recommendations

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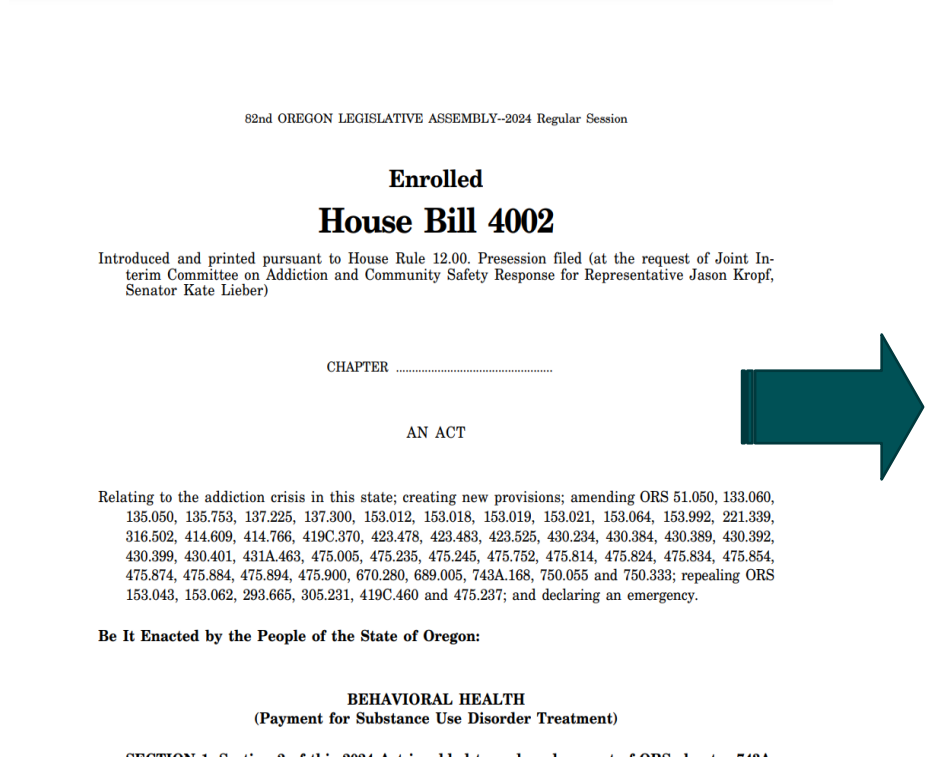
House Bill 4002: Key Provisions



82nd OREGON LEGISLATIVE ASSEMBLY--2024 Regular Session

Enrolled

House Bill 4002

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of Joint Interim Committee on Addiction and Community Safety Response for Representative Jason Kropf, Senator Kate Lieber)

CHAPTER .....

AN ACT

Relating to the addiction crisis in this state; creating new provisions; amending ORS 51.050, 133.060, 135.050, 135.753, 137.225, 137.300, 153.012, 153.018, 153.019, 153.021, 153.064, 153.992, 221.339, 316.502, 414.609, 414.766, 419C.370, 423.478, 423.483, 423.525, 430.234, 430.384, 430.389, 430.392, 430.399, 430.401, 431A.463, 475.005, 475.235, 475.245, 475.752, 475.814, 475.824, 475.834, 475.854, 475.874, 475.884, 475.894, 475.900, 670.280, 689.005, 743A.168, 750.055 and 750.333; repealing ORS 153.043, 153.062, 293.665, 305.231, 419C.460 and 475.237; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

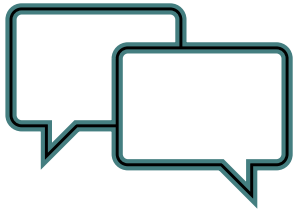
BEHAVIORAL HEALTH
(Payment for Substance Use Disorder Treatment)

By December 1, 2024, recommendations to address the safety concerns that are prevalent in the behavioral health industry, including […]:

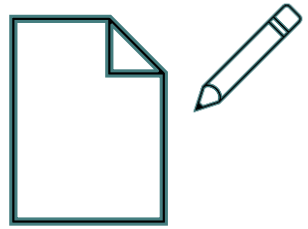
- Physical and structural security
- Safe staffing levels
- Safety protocols and procedures
  - Minimum standards
  - Training requirements and best practices
  - Standards for reporting assaults
- Strategies to ensure compliance
- Potential sources of funding for implementation

List of Potential Concepts

Your initial feedback was captured during 3 topical meetings



You discussed a list of issues and ideas in each topical domain



From your feedback, staff updated list of ideas for the Chair

Chair and staff present list of policy concepts today for discussion

Getting to the Final Report

Today

Consider recommendations

- Review list of policy concepts
- Discuss what should move forward as recommendations

November 7th

Finalize recommendations

- Review revised concepts
- Narrow to areas of agreement, finalize recommendations
- Review draft report

November 14th

Finalize report

- Review revised draft report
- Final feedback to staff
- Adopt report (with revisions as needed)

Concepts to Recommendations

- List of concepts is organized by policy domain in the order discussed
    - Some ideas (e.g. safety plans) appear in multiple domains
    - Can be grouped differently in the report for clarity, as needed
- Tips for recommendations
    - Who is doing what?
    - By when?
    - If multiple steps are required, are they reflected and in the right order?
- Language used in Task Force recommendations may differ from bill language
    - Language should capture the Task Force's intent

Your input in July: What will success look like?

Near-term

Changes in awareness and knowledge

- Understanding of best practices
- Awareness of potential unintended consequences

Changes in policy

- Roadmap for legislation and new investments
- Proposals that can be incorporated into agency rulemaking

Long-term

Recommendations that

- Reduce violent incidents over time
- Increase safety without increasing unnecessary litigation against consumers
- Offer a framework for employer accountability
- Share responsibility among OHA, ODHS, CCOs, and providers

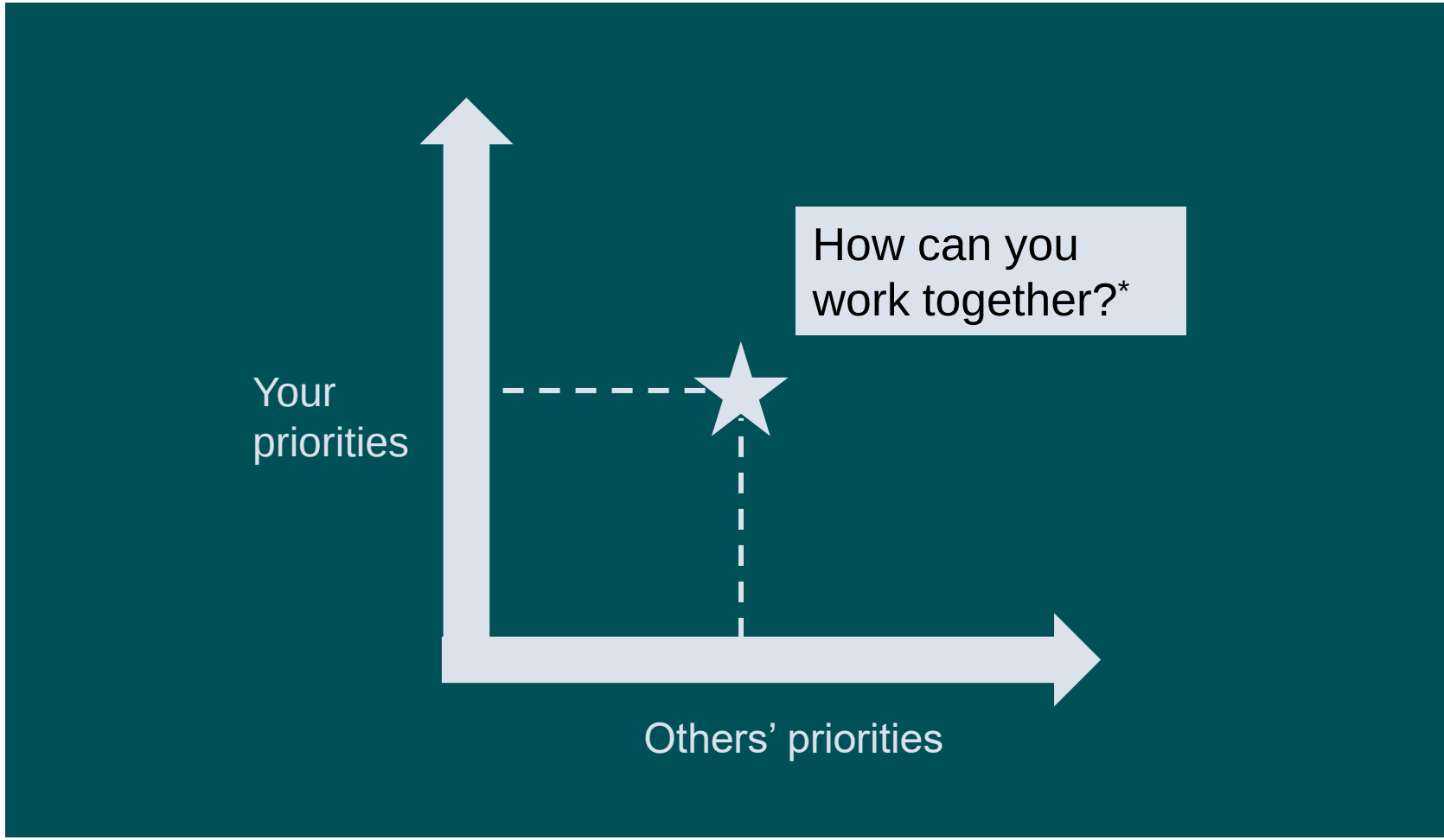
Consensus and Decision Making

From Task Force operating procedures (adopted July 11, 2024):

> *“Consensus is a participatory process whereby, on matters of substance, members strive for agreements that they can accept, support, live with, or agree not to oppose.*
>
> *Consensus means that no members voiced objection to the position, and they agree not to oppose the position.”*

Where to go from here?

- Consider how this group defined success
- Identify shared priorities from your past discussions
- Consider where you can reach agreement in the time available



*Adapted from National Policy Consensus Center, 2024

Policy Concepts

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Written Safety Plans

1.1) Behavioral health employers should be required to develop a written safety plan. This requirement should apply to traditional settings as well as shelters and mobile crisis units. Safety plans should be tailored to the employer's specific context and easily accessible by staff. Employers should be required to provide a copy of the written plan to new workers upon hire.

1.2) *[OHA?]* should offer incentives to behavioral health employers to encourage timely development of written safety plans. Incentives should be offered up-front to cover employer costs with a requirement to provide evidence of completion. OSHA should work with OHA and ODHS to advertise to behavioral health providers that free consultation and training on safety planning are available to them.

1.3) There should be enhanced penalties for employers if, during the course of an investigation, OSHA determines that an employer was not in compliance with requirements related to a written safety plan.

Safety Training – What, When, How

1.4) Behavioral health employers should be required to provide:

- **basic safety training** addressing common risks and the written safety plan (distinct from de-escalation). The training should include add-on components for specific settings and levels of care. One add-on should be field safety training for mobile crisis.
- **de-escalation training** when a new worker is hired and periodically thereafter (e.g., every 3-4 years).
- **training on workers' rights and reporting options** when they are concerned about workplace safety including working alone. Training must include information about retaliation protections, how to report concerns to the Bureau of Labor Industries or Oregon OSHA, etc.

Trainings should be provided at initial onboarding. The requirement should apply to traditional behavioral health settings as well as shelters and mobile crisis units. De-escalation training must be delivered by live instructors, in-person, with interactive elements. [OHA and ODHS?] should develop standard training curricula for basic safety and workers rights that are offered on a rolling basis to all employers. Larger employers may elect to deliver the agency's basic safety training and workers' rights and reporting options curriculum using a train-the-trainer approach. To the extent practicable, trainings should be delivered by live instructors, in-person or virtually, and incorporate interactive elements. Employers should minimize reliance on prerecorded content.

Safety Training – Record Keeping

1.5) OSHA should require employers to document that new workers complete required trainings within 90 days. Employers should be required to [regularly?] lead workers in practice or “drills” of training content. OSHA should impose penalties when employers do not comply.

Agency Rules Alignment

1.6) OSHA, OHA, and ODHS should review information from providers about perceived tensions between agency rules for client and worker safety. The agencies should review rules regarding client neglect or abuse and identify where specific guidance related to assaultive behaviors toward workers is not addressed. The agencies should use this review to develop guidance on how employers can comply with rules. The agencies should provide a report on these activities to the Legislative Assembly by [date?].

1.7) OSHA, OHA, and ODHS should be directed to increase coordination during 1) enforcement of regulations related to safety of clients and workers, and 2) investigation of incidents involving violence between a client and worker. The agencies should develop a process for providers to seek guidance when they perceive tension between safety requirements of the agencies. *[note: may require federal consultation related to HCBS regulations]*

Agency Rules - Admissions

1.8) OHA rules should permit a provider to consider a client's full history when determining suitability for admission. The agency should not limit the lookback period to 14 days.

Critical Incident Logs

1.9) OSHA should develop a critical incident template for use by behavioral health providers to track “near misses”. The form should be simple to fill out and designed to complement an assault log.

1.10) Behavioral health employers should [be encouraged or required?] to:

- maintain a log of “near miss” critical incidents that do not meet the definition of assault.
- hold “after action meetings” following a critical incident.
- review critical incidents and assault logs when developing an employer’s written safety plan.

Lone Worker Protections

2.1) Behavioral health employers should be required to either 1) offer a communication device to any employee who may be alone with a client, or 2) allow workers to require a second staff member be present before working with a client.

2.2) As part of a written safety plan, behavioral health employers should be required to assess situations where a worker may be alone with clients on the job. The plan should address 1) how the employer will provide communication devices to workers, and 2) when and how workers can request another staff member be present when working alone with a client.

OHA Rate Study

2.3) OHA should engage an actuary to gather information from providers to:

- model the cost to raise the minimum staffing requirement for behavioral health facilities to two workers.
- model the cost of structural security elements or safety planning policies recommended by the Task Force.

This cost information should inform the agency's rate updates for behavioral health providers. The agency should study potential pathways to secure federal approval and financial participation (i.e. Medicaid match) for enhanced staffing or structural requirements. Findings should be reported to the legislative assembly by *[date?].*

OHA Payment Methodologies

2.4) OHA should reduce the processing time for providers to request a rate exception and develop a fast-track option for emergent situations where a residential client's behavior rapidly changes.

2.5) OHA should require CCOs to implement payment models for outpatient mental health providers that are adjusted for client acuity.

2.6) OHA should require CCOs to use prospective payment models that support two-person mobile crisis teams. Payments should be population- or retainer-based (e.g. a "firehouse model") to ensure all areas of the state maintain ongoing mobile crisis capacity.

Assessment of Built Environment

3.1) As part of a written safety plan, behavioral health employers should be required to assess the built environment and how it may support or impede self-defense by a worker who is being assaulted. Components of the assessment should include: [TF members to add suggestions?]

Support for Structural Security Changes

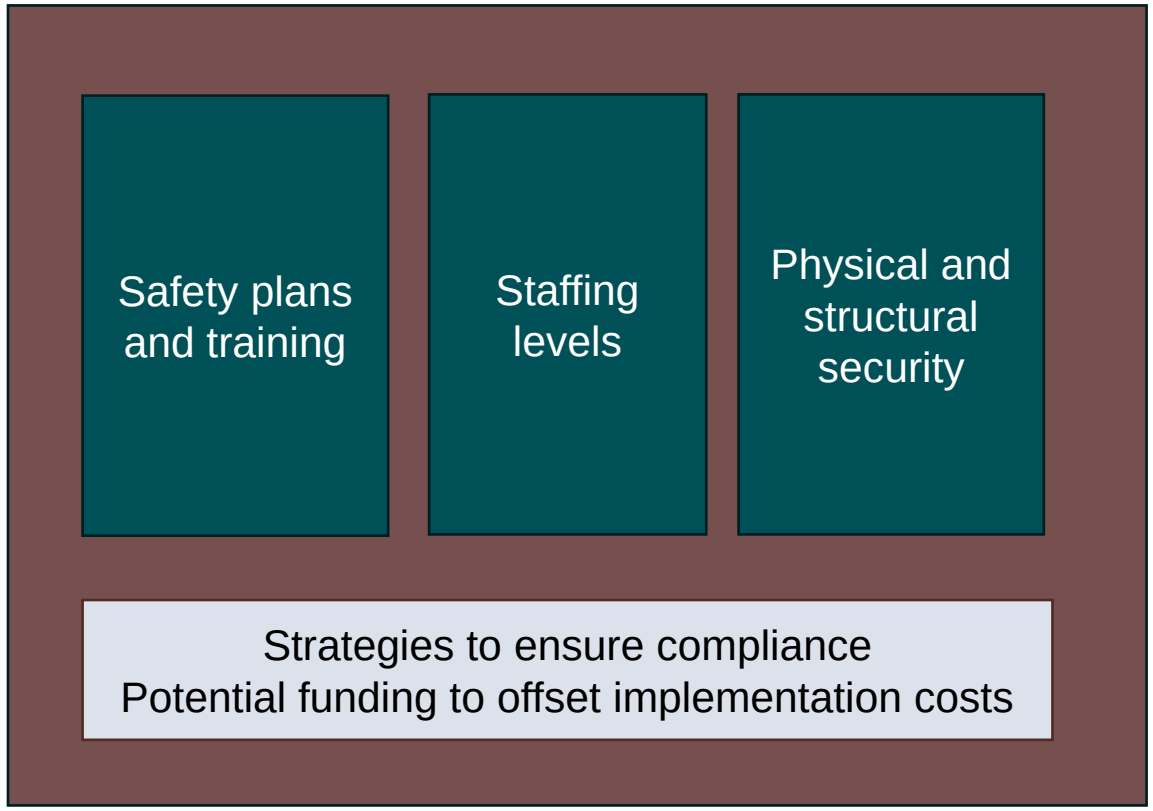
3.2) The legislative assembly should:

- Appropriate general funds and direct [OHA?] to offer grants to behavioral health providers to retrofit existing facilities with safety enhancements such as keyless entries (e.g. fobs or biometric scanners) and panic buttons.
- Require that any newly constructed behavioral health facilities receiving public funding must include elements to enhance worker safety in the facility's design.

Discussion

- Which of these concepts are your highest priorities?
- Any concepts that you could not support without changes?
- Any concepts that could be more specific?
    - Strategies for compliance
    - Funding sources

Mapping Topics to Workplan



Draft Workplan	
Today	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

Connecting with the Public

- **Live-stream:** Capitol viewing station and on OLIS Task Force site:
  - Use the link for materials and recordings
- **Public Comment:**
  - Sign up prior to meeting, or
  - Comment in writing: JTFBHW.exhibits@oregonlegislature.gov
- **Language Access** (interpretation, translation, CART)**:** https://www.oregonlegislature.gov/lpro/Pages/language-access.aspx