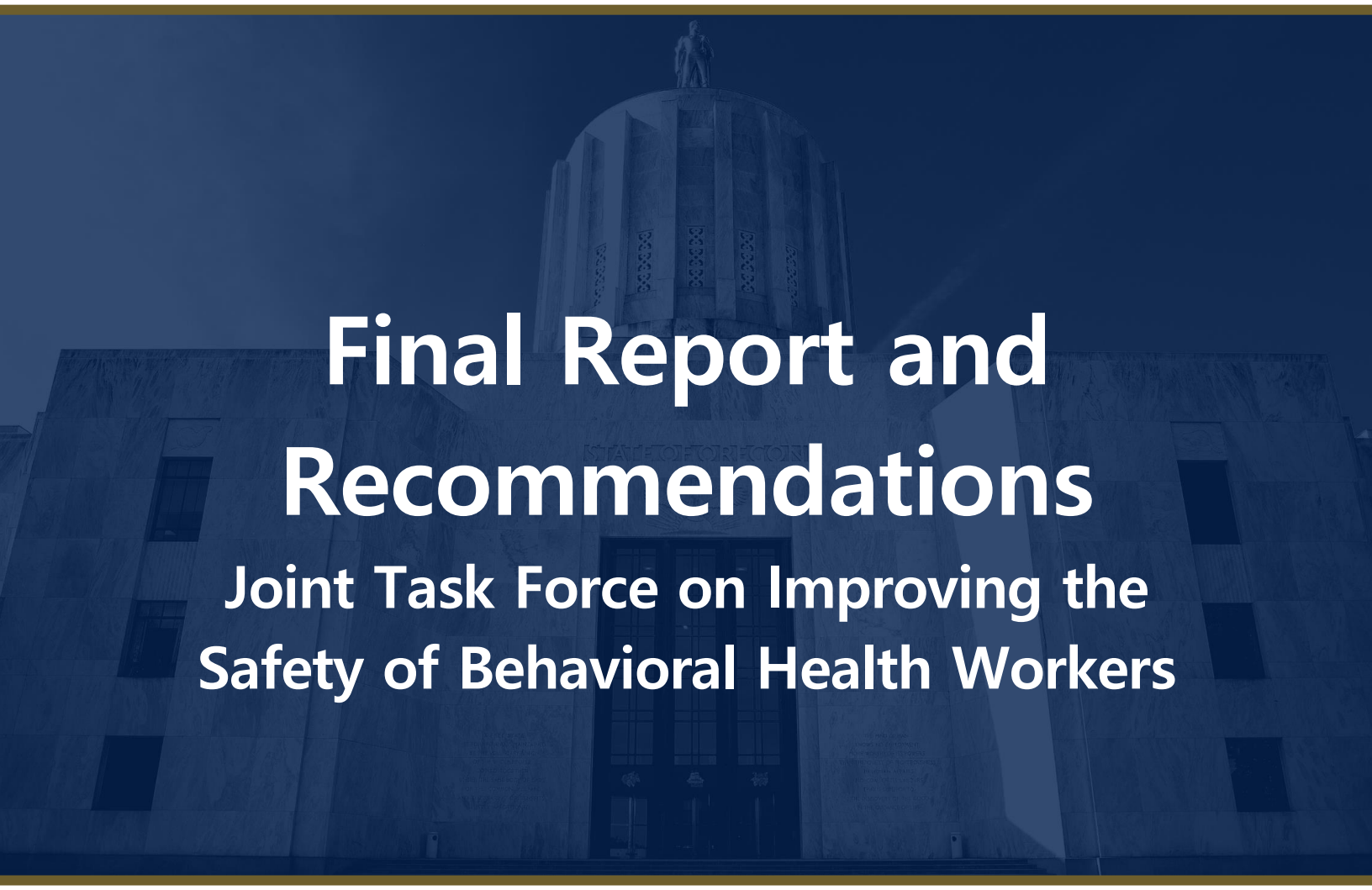

Final Report and Recommendations

Joint Task Force on Improving the Safety of Behavioral Health Workers

About this Report

This Task Force was created in 2024 by House Bill 4002 to address the safety concerns that are prevalent in the behavioral health industry

The Task Force was charged with making recommendations, including drafting legislation, to address the safety concerns in the behavioral health industry by type of facility or workplace setting. The Task Force developed recommendations: a) to improve the physical and structural security of a behavioral health facility, b) that address safe staffing levels, c) to identify standards and procedures for reporting assaults, d) to identify best practices for worker safety training, including minimum requirements for training on workplace safety protocols; and e) to establish minimum standards for safety protocols and procedures. In addition, the Task Force was charged with the development of recommendations to ensure compliance with all worker safety and training requirements and identify sources of funding to mitigate the costs incurred by implementing any of the recommendations.

Legislative Members (Non-voting):

Senator Lynn Findley, Senate District 30

Senator Chris Gorsek, Senate District 25

Representative Travis Nelson, House District 44, Chair

Representative Cyrus Javadi, House District 32, Vice-Chair

Non-Legislative Members (Voting):

Devarshi Bajpai

Dr. Ryan Bell

Dave Boyer

Clay Cruden

Stacy England

Jeremy Lankenau

Alexander Mackaben

Linda Patterson

Anna Pena

Eric Sevos

Matt Swanson

Sommer Wolcott

Penny Wolf-McCormick

Staff

Alexandra Kihn-Stang, Legislative Analyst

Whitney Perez, Legislative Analyst

Shauna Petchel, Research Analyst

Erin Seiler, Legislative Analyst

Matt Wurst, Committee Assistant

Legislative Policy and Research Office

Oregon State Capitol | (503) 986-1813 | www.oregonlegislature.gov

Executive Summary

Joint Task Force on Improving the Safety of Behavioral Health Workers

DATE: November 14, 2024

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Executive Summary

Joint Task Force on Improving the Safety of Behavioral Health Workers

DATE: November 14, 2024

Section 1: Task Force Process

Charge and Background

In 2024, the Legislative Assembly heard concerns from behavioral health workers about their exposure to workplace violence. House Bill 4002, enacted during the 2024 short session, established the Joint Task Force on Improving the Safety of Behavioral Health Workers. The Task Force was directed to develop recommendations to "address the safety concerns that are prevalent in the behavioral health industry," including safety plans and training, physical and structural security, and staffing levels. The Task Force was to consider strategies to ensure employer compliance with recommended changes, as well as funding sources that could offset the cost of changes.

The Legislative Assembly directed the Task Force to submit preliminary recommendations by September 1, 2024, and final recommendations by December 1, 2024.

The Task Force consists of 17 members, including four legislators and 11 community representatives appointed by the Speaker of the House and Senate President and two representatives of Oregon Occupational Safety and Health Administration (OSHA) appointed by Governor Tina Kotek.

Per House Bill 4002, Task Force membership represents a range of sectors including behavioral health employers, behavioral health workers, representatives from organized labor, consumers of behavioral health services, Oregon OSHA, Disability Rights Oregon, and Oregon State Hospital.

With support from the Legislative Policy and Research Office (LPRO) and state agency partners, the Task Force began its work by assessing needs and opportunities within the policy domains (see Appendix A). All Task Force members completed a needs assessment that included questions about member goals, priorities for the Task Force's work, and initial information requests. LPRO utilized the information to assist in the drafting of a Task Force workplan; overall goals for

the work; ideas regarding policy needs and opportunities; and what tools are necessary to help develop recommendations.

At the second Task Force meeting on August 7, the Chair presented the Task Force with a workplan that included meetings dedicated to discussion and considerations of needs, issues and recommendations for each policy domain in the HB 4002 (see Appendix B). The short timeline between when the full Task Force was appointed on July 2 and when it adopted the final report on November 14, limited the Task Force's ability to engage subject matter experts, members of the behavioral health community, and the public in its examination of problems and discussion of potential recommendations.

Needs Assessment

Members participated in a needs assessment survey to identify overall goals, policy opportunities, and urgent priorities with regards the policy domains outlined in House Bill 4002: safety plans and protocols, staffing levels, and physical and structural security.

Members identified certain near-term goals for their work.

The goals included:

- increasing shared knowledge about best practices for safety in various settings;
- recognizing potential unintended safety consequences of existing or proposed policies;
- developing a roadmap for potential legislative changes in 2025; and
- proposing strategies that could be incorporated into new agency administrative rules.

Members also offered the following long-term outcomes as criteria that could help guide their selection of recommendations:

- measurably reducing violent incidents against workers over time;
- avoiding unnecessary litigation or charges against behavioral health consumers;
- offering an accountability framework for employers; and
- sharing accountability for worker safety among Oregon Health Authority (OHA), Oregon Department of Human Services (ODHS), coordinated care organizations, and providers.

Members offered a range of more detailed needs and opportunities for the group's consideration in the three policy domains (see Exhibit XX).

Exhibit XX: Policy Domains and Initial Member Ideas

Domain	Initial Member Ideas
Safety Plans and Protocols	• safety plan templates and sample policies; • required or recommended contents for employer policies; • trainings including new options for de-escalation (beyond the Crisis Prevention Institute's Non-Violent Crisis Intervention training; and • standards for reporting, investigating, tracking assaults.
Staffing Levels	• staffing minimums ("No one should work alone"); • specific roles needed (monitoring camera feeds, maintaining and repairing safety equipment); • how to pay for staffing (rates, exception processes and timelines); and • contingency plans or guidance when employers cannot meet minimum staffing.
Physical and Structural Security	• systems for monitoring staff safety (communication devices, cameras, surveillance software); • structural elements (windows, doors, locks, furniture); and • layout of buildings or settings (sight lines, escape Needs and opportunities routes)

Source: Legislative Policy and Research Office

The complete summary of members' responses was presented to the Task Force on August 7. The summary and LPRO presentation of the assessment results are available on OLIS for review.

Workplan and Meeting Materials

The Task Force met eight times between July 2024 and November 2024.

The workplan was organized into three distinct phases of work:

- **Phase #1: Getting Started:** July 18 and August 7
- **Phase #2: Information Gathering**: August 30, September 10, and October 3
- **Phase #3: Deliberations:** October 18, November 7, and November 14

The workplan was served as roadmap for the Task Force to study and consider each policy domain in more detail.

Preliminary Report on September 1, 2024

The Task Force was responsible for submitting to the interim committees of the Legislative Assembly related to health by September 1, a preliminary report containing draft policy recommendations to address the safety concerns that are prevalent in the behavioral health industry including recommendations, by type of behavioral health facility or workplace setting.

Prior to September 1, the Task Force held three Task Force meetings, two focused on organizational tasks such as election of chair and vice-chair; review of the needs assessment; and scoping the policy domains and one on the legislative history that led to the creation of the Task Force in HB 4002. The Task Force did not have enough time to develop draft policy recommendations for inclusion in the preliminary report.

Therefore, the preliminary report provided an update on the work of the Joint Task Force on Improving the Safety of Behavioral Health Workers. It included information regarding the background and charge of the Task Force, Task Force Membership, Initial Assessment and Planning, and process for development of recommendations for the Legislative Assembly by December 1, 2024. The preliminary report was adopted unanimously by the Task Force on August 30.

Public Testimony

Section 2: Analysis of Policy Options

The Task Force considered unmet needs and potential policy options in three domains (see Exhibit XX):

1. Safety plans and protocols;
2. Staffing levels; and,
3. Physical and structural security.

Within each domain, they considered the supports and resources providers would need to implement new requirements, options to ensure employer compliance, and potential funding mechanisms the state could access or make available. An overview of these analyses is provided below.

Exhibit XX. HB 4002 and Policy Domains of Focus

Source: Legislative Policy and Research Office

Domain 1: Safety Plans and Protocols

On August 30, 2024, the Task Force began analysis of this domain by learning about existing safety plan and assault log requirements, best practices in violence prevention in behavioral health settings, current violence-related trainings in behavioral health settings, and preventing retaliation for reporting assaults.

Oregon OSHA Overview of Existing State Law and Regulation

On August 30, 2024, a member of the Task Force, Penny Wolf-McCormick who is the Statewide Health Enforcement Manager from Oregon Occupational Health and Safety (Oregon OSHA) provided an overview on how the federal government and

the State of Oregon establish rules related to workplace health and safety. In 1970, the national Occupational Safety and Health Act established the Occupational Safety and Health Administration (federal OSHA). Under this law, every state is required to either operate under federal OSHA regulations or enact their own state plan with the same or higher standards for safety. In 1973, Oregon enacted the Oregon Safe Employment Act and created its own state plan. Oregon is monitored quarterly by federal OSHA and any state OSHA rules must be inspected federally.

The Oregon Safe Employment Act contains certain specific requirements and authorizes Oregon OSHA to develop safety and health rules. Rules can be promulgated in several ways.

- When federal OSHA adopts a rule, Oregon OSHA has 180 days to either adopt the same rule or develop a similar rule that is at least as effective;
- Oregon's legislature or its Governor can direct Oregon OSHA to adopt a rule; and,
- Emerging trends and new hazardous situations may cause the agency to develop a new rule. This can occur through requests from unions, industry groups, or specific employer requests.

When Oregon OSHA develops a new rule, they are required to include a report of the economic feasibility of implementing the rule. Rules can be broad or specific. Broad rules, which address a wide variety of situations, do not give specific details to the employer on how to comply, and therefore it can be harder to prove a violation of these rules. Specific rules typically address narrow situations, are more straightforward, and offer specific details to employers on how to comply.

Oregon OSHA reviewed workplace health and safety rules that can apply to health care settings including behavioral health. Oregon health care entities can fall under one of two categories for OSHA regulation:

1. **Hospitals, surgical centers, and home healthcare agencies** are subject to specific statutory requirements in ORS 654.412. These are further detailed in OSHA Program Directive A-267 (2008).
2. **All others, including most behavioral health entities**, are subject to OSHA's Division 1 rules, further detailed in Program Directive A-283 (revised 2017) which was published by federal OSHA and adopted by Oregon OSHA.

OSHA provided information on Oregon statutes that relate to workplace violence and address health care employers. These are outlined in Exhibit XX below.

Exhibit XX. Oregon Statutes Regarding Healthcare Workplace Safety

Provider Type	Statutory Requirements
Hospitals and surgical centers	**ORS 654.412 through ORS 654.423** applies specifically to hospitals and surgical centers. The statute specifically excludes most health care providers, including: • Offices of private physicians; • Residential facilities licensed by OHA, ODHS or Department of Corrections; • Residential facilities for treatment of substance use disorders; • Community mental health programs or community developmental disability programs; and, • Establishments primarily providing housing. Hospital and surgical center employers are required to: • Conduct periodic security and safety assessments that meet certain standards; • Develop and implement an assault* prevention program based on the assessment. Among other things, this must include staffing plans and procedures for reporting assaults. The law requires employers to engage their workplace safety committee in reviewing the program at least every two years; • Provide assault prevention and protection training to workers on an ongoing basis. This requirement outlines several specific topics that training must address. Employees must be trained within 90 days of hire; and, Maintain an assault log, which is a critical input to planning by the employer and its' workplace safety committee. However, the time involved in maintaining the assault log can be a barrier.
Other facility types	Oregon OSHA follows a broad "general duty clause" for health care employers not covered by the more specific entities contained in ORS 654.412. The general duty clause requires that:

- Employers shall "furnish employment and a place of employment which are safe and healthful for employees…" While it covers a broad range of scenarios, it is more difficult to enforce;
- Workers are "properly instructed and supervised in the safe operation of any machinery, tools, equipment, process or practice…" and,
- Where there is a known hazard, the employer uses "all reasonable means and methods" necessary to keep workers safe.

Oregon OSHA also requires a workplace safety committee and safety meetings of all employers in Oregon. The safety committee must:

- Meet monthly on work time and keep minutes of meetings;
- Be trained in hazard identification and accident investigation;
- Be composed of members who represent the majority of activities of the employer;
- Have an equal number of management-selected members and employee-selected members; and
- Investigate lost-time injuries and make recommendations to prevent recurrence.

The employer is required to respond to the workplace safety committee recommendations. Employers are also required to assess the workplace for any hazards that may require personal protective equipment (PPE), and where present, provide the PPE for use.

Note: ORS 654.412(1) defines assault as "intentionally, knowingly or recklessly causing physical injury". Violence that does not meet this definition may not be considered an assault.

Source: Legislative Policy and Research Office

Oregon law also provides certain rights for workers, including:

- A hospital or surgical center employee who has been assaulted by a patient can require that another worker be present in any future treatment of that patient;
- A home health worker can require a second employee to be present when treating a patient if the employee believes the patient may assault them, based on the patient's past behavior or physical or mental condition;
- A home health worker can require a communication device for reporting assaults before treating a patient; and,

- A right to use physical force in self-defense against an assault.

Oregon OSHA reviewed suggested control measures that federal OSHA has determined can be effective in reducing workplace violence. The guidance varies by setting type, and includes:

- Security/silenced alarm systems;
- Exit routes;
- Metal detectors – hand-held or installed;
- Monitoring systems and natural surveillance;
- Barrier protection;
- Patient and client areas that support de-escalation;
- Furniture and materials that are appropriate and maintained; and,
- Discretion for working alone in nonsecure areas.

The Task Force members discussed key points following the presentation including process for requesting a rule change with Oregon OSHA, facility exemptions from Oregon OSHA, tension or conflict between Oregon OSHA rules and Oregon Health Authority (OHA) rules, and establishing the elements required to prove assault when a person has a mental health condition.

The Joint Commission: Perspective on Best Practices

The Task Force heard from representatives from The Joint Commission (TJC). The Joint Commission provided an overview of their new workplace violence prevention standards for behavioral health and human services organizations which were published in January 2024. TJC offers accreditation for health care organizations and helps these entities assess and improve care. TJC defines workplace violence as "an act or threat occurring at the workplace that can include any of the following: verbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying, sabotage, sexual harassment; or, physical assaults involving staff, patients, or visitors."

The Joint Commission considers "sentinel events" to be those that result in death or serious harm to a worker or client and are not related to the course of a condition or illness. Their accredited behavioral health organizations are expected to do a root-cause analysis when a sentinel event occurs. From these analyses, TJC noted common contributing factors can include:

- **Communication issues,** such as inadequate staff during transitions or information that is not transferred between care team members;
- **Management issues,** such as not having clear policies or procedures in place, having unclear roles, or not following the procedures; or,
- **Environmental issues,** such as poor visibility or line of sight in a physical workspace.

TJC follows a standard framework to guide behavioral health organizations in developing plans for workplace violence prevention. Components of an effective employer approach include:

- Having a workplace violence prevention program with leadership oversight;
- Clear policies and procedures;
- Clear post-incident strategies;
- Collecting and analyzing data on violence incidents; and,
- Training and educating workers.

TJC noted that within behavioral health there is often a cultural norm or perception that experiencing violence or harassment is a part of the job. This cultural norm undermines creation of effective responses.

The required standards of their accredited behavioral health organizations include:

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

Accredited organizations develop their own tailored plans to meet the standards, with consideration for their setting and context. However, TJC does provide specific detail on what topics should be addressed in safety trainings, including:

- Definitions and examples of workplace violence;
- The responsibilities of leadership, staff, security personnel and law enforcement;
- Training in de-escalation, nonphysical and physical intervention techniques, and emergency response; and,
- The employer's reporting process for violence incidents.

TJC suggested that employers implementing these standards should aim to 1) keep plans reasonable, building on and formalizing processes already in place when possible, and 2) make plans tailored to specific work sites rather than a one-size-fits-all model. Their Workplace Violence Prevention Resource Center offers published tools and information to support implementation of these approaches.

The Task Force and presenters discussed what types of facilities TJC accredited, consequences when a facility does not meet the required standards, and process for updating standards.

Oregon Bureau of Labor and Industries Overview of Worker Rights

The Task Force also learned about worker protections when workplace safety issues arise. The Task Force heard from member Penny Wolf-McCormick from Oregon OSHA and representatives from the Oregon Bureau of Labor and Industries (BOLI).

In industries like health care, enforcement of OSHA rules largely depends on workers identifying hazards, reporting complaints, and participating in investigations. If workers do not participate in these activities, the state's health and safety protections become functionally void. The Oregon Safe Employment Act (ORS 654.062):

- Protects workers from retaliation if they complain about workplace health or safety hazards, whether to their employer or to Oregon OSHA; and,
- Establishes a worker's right to refuse work when there is a danger of serious physical harm or death, there is insufficient time for Oregon OSHA to inspect, and the employee has been unable to obtain correction of the dangerous condition from the employer.

These protections are enforced by the Civil Rights Division of Oregon's Bureau of Labor and Industries (BOLI) and are in addition to the rights reviewed by Oregon OSHA.

Under Oregon law, three conditions establish that retaliation has occurred:

- A worker engages in a protected activity, such as reporting a workplace hazard;
- An adverse action is taken by the employer (for example: firing/laying off, disciplining, intimidation, making threats, or reducing pay or hours); and,
- There is a connection between the protected activity and the adverse action.

In practice, it can be difficult to establish that an adverse action was taken *in response to* a worker engaging in a protected activity. This challenge has resulted in a low rate (nationally and in Oregon) of complaints where the employer is found at fault. For this reason, ORS 654.062 was recently amended to establish a presumption that a connection does exist unless the employer can prove otherwise.

Oregon OSHA and BOLI operate under an inter-agency agreement where BOLI investigates complaints of retaliation or discrimination related to workers' OSHA rights. The investigation process generally includes:

1. Intake screening immediately upon notice of a complaint;
2. Sending a notification letter to the employee and employer requesting information;
3. Interviewing the employee about the allegations; and,
4. Investigating the complaint through fact finding and additional interviews.

Oregon state law establishes a statute of limitations of one year to file a complaint. Outcomes can include a settlement (prior to BOLI concluding its investigation), a conciliation agreement where the employer and worker mutually agree to conditions to close the case, or a merit (or "cause") determination that results in further corrective action against the employer. BOLI's ability to protect employees from retaliation is a critical element of Oregon's framework for worker health and safety. However, the BOLI investigation process is slow and can take between five and 18 months from when an incident occurs.

Task Force members discussed with presenters what types of retaliation has occurred and how widespread retaliation was within the behavioral health setting.

Current Requirements for De-Escalation Training

On September 10, 2024 the Task Force concluded analysis of this domain with a presentation from LPRO staff about employee training requirements of OHA and the Oregon Department of Human Services (DHS). OHA and DHS provide regulatory requirements for de-escalation training for institutional providers, home and community-based providers, and certain other entities such as detox centers. Most settings have regulatory requirements for de-escalation training or techniques. However, these requirements vary in detail, prescriptiveness, and content.

Task Force members discussed perspectives on safety protocols and training following this presentation. Members noted the importance of accessibility and consistency in trainings, the role of de-escalation trainings in certain care settings, challenges in effective safety planning, and the need for additional resources and support from the State.

Member Discussion of Priorities for Recommendations

On September 10, 2024, Task Force members discussed their priorities for recommendations related to safety plans and protocols.

Members began by discussing de-escalation trainings not meeting current needs for a variety of reasons: too prescriptive, not relevant to the setting type, not detailed enough to be useful, or not widely available to all workers who needed them. Members discussed the need to distinguish between de-escalation trainings and safety trainings, and to develop trainings that are appropriate to a work setting and environment. Discussion included the value of different types of trainings, such as virtual, in-person, and train-the-trainer models. The importance and feasibility of de-escalation trainings occurring upon hire and at regular intervals was included in discussion.

Members also discussed concerns that safety plans were not consistently occurring, and enforcement of safety planning was contingent on complaints. Employees are not always aware of or trained on what their rights are and what is a reportable complaint, and worker turnover can undermine the effectiveness of existing training. Task force members discussed whether safety plans should be statutorily required to be in writing and whether the current requirement to provide hospital employees training within 90 days of hire was sufficient. Members discussed current penalties for non-compliance with safety plan and training requirements and incentives for compliance.

Members next discussed administrative rules for facility regulation. Discussion included whether current administrative rules addressed employee safety needs.

Task Force members discussed employer and employee experiences with tensions complying with existing Oregon OSHA rules for worker safety and OHA/DHS rules for client care. Members discussed employer challenges with meeting state rules while protecting employees and that rules for certain facility types, like residential facilities, eliminate an entity's ability to control who enters a program and when.

Members went on to discuss Oregon's definition of assault. ORS 654.412(1) defines assault as "intentionally, knowingly or recklessly causing physical injury". Violence that does not meet this definition may not be considered an assault. It was discussed that violence resulting from mental illness may not meet this definition and therefor these assaults would not be captured in required assault logs. Members discussed the use of assault logs in developing a safety plan, whether it was viable to change the current definition of assault, and the utility of capturing all violent incidents or near violent incidents in assault logs.

Finally, members discussed the need for safety plan requirements to include other settings, such as shelters, mobile crisis units, and other community-based settings. Members noted challenges with imposing new requirements through OHA/DHS because these settings are regulated through different pathways, if at all. Members discussed whether expanding safety plan requirements beyond hospitals to other settings was appropriate given the different size and capacity of community-based settings. Members discussed a possible need for enhanced technical assistance to help employers in complying with existing OSHA rules and other options for increasing awareness to employers and employees of existing safety rules.

Domain 2: Safe Staffing Levels

The Task Force analyzed options in this domain by considering legal protections for people working alone, minimum staffing requirements the state imposes on providers, and how these rules relate to the payment models and reimbursement structures in use in the state's Medicaid program. These analyses are detailed below.

Lone Worker Policies and Protections

On September 10, 2024, the Task Force began analysis of this domain with a presentation from LPRO staff on the Oregon Safe Employment Act, ORS Chapter 654, and an overview of lone worker policies.

Lone Workers are:

- 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; or,
- Workers who 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 encompass a broad category of policies to mitigate safety risks specific to lone workers. Components of these policies include: assessing and managing areas of risk, establishing training requirements, and putting systems in place to maintain communication. There is no comprehensive Oregon or federal OSHA standard. However, there are 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).

Lone worker policies in the health care setting are 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; and,
- **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 has SHB 1456 (2007), also known as the Marty Smith Law. This law was 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 are that it:

- 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, and,
- Requires annual worker training on safety and violence prevention.

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

Funding associated with the Marty Smith Law 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 contained in 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; and,
- Resources for employees for coping with the effects of violence.

LPRO staff received implementation information from Washington SEIU (1199nw) and conveyed that to the Task Force. 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 professional 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 LPRO staff to share a recent story with the Task Force 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 and presenters discussed how the Marty Smith Law compared to policies in Oregon and what provider types were included within the Marty Smith Law.

Medicaid Reimbursements and Minimum Staffing Requirements

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

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:

- **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;
- **Qualified directed payments** for behavioral health separately set at minimum payment levels CCOs must pay outpatient behavioral health providers; or,
- **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; and,
- **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 services** (SUD) 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; and,
- **Inpatient psychiatric** stays are paid a base rate developed from modified Diagnosis-Related Groupings (DRG) with additional per diem amounts after 30 days.

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 were scheduled to be presented to OHA leadership in September to inform rate updates toward the end of 2024.

Exhibit XX. Provider Types and Payment Methodologies

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

Provider	Payment Methodologies
	• 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

Source: Legislative Policy and Research Office

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.

Exhibit XX. Provider Type, Maximum Capacity and Minimum Staffing Requirements

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*

Source: Legislative Policy and Research Office

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; and,
- 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; and,
- 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.

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; and,
- 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.

Task Force members and presenters discussed how Oregon reimbursement rates compare to Washington and California and what impact potential lone worker policy changes would have on costs. Members discussed with the presenters the rate exception review process and potential changes to the reimbursement process. Discussion also included whether reimbursements could include pathways for safety plan requirements or structural security.

Member Discussion of Priorities for Recommendations

On October 3, 2024, Task Force members discussed their priorities related to safe staffing levels.

Members began by discussing concerns around safety risks when a worker is alone. Oregon has some limited lone worker protections that apply to home health, home care, and hospital workers. Other workers are not covered except by a general right to refuse unsafe work situations. Otherwise, employers are not currently required to

provide additional staff or communication technology, such as panic buttons, to lone workers in most behavioral health settings. Members discussed the need for workers to be trained or provided notice on lone worker policies, and the right to refuse work in unsafe environments. Members also discussed whether workers should be able to request a second worker when performing certain duties and the need for certain safety technology.

The current minimum staffing requirement in many residential and community-based behavioral health settings is for a single worker. Current Medicaid reimbursements would not cover the cost for higher minimum staffing requirements. The cost to employers of increasing staffing requirements is not known. Members discussed issues that a potential increase to minimum staffing requirements could cause, such as requiring workers to take additional shifts, given current workforce shortages. Members discussed alternatives to increasing staffing requirements, such as de-escalation training or self-defense training.

Members also discussed issues around OHA's fee-for-service reimbursements for outpatient mental health, SUD, and residential care not being adjusted based on client acuity or additional staffing needs required in a client service plan. Additionally, the current process to request a rate exception can take two weeks, with providers absorbing the cost of additional staff during this time.

The current payment methodology for mobile crisis intervention teams is a FFS approach that does not cover the cost of maintaining two-person teams at all times over a 24-hour period. Members discussed the different payment models for mobile crisis services in Oregon and the benefits of a prospective payment model.

Task force members discussed that OHA's Medicaid rate setting processes may not capture employer's 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. Members discussed a need to study how Medicaid rates could be used to cover these types of costs and whether additional state funding should be invested in safety enhancements.

Domain 3: Physical and Structural Security

The Task Force learned about this domain by reviewing analysis of workers' compensation claims, hearing from industry experts on best practices for structural security in behavioral health facility design, and receiving an overview of current regulation of facilities by Oregon agencies. These analyses are detailed below.

DCBS Analysis of Workers Compensation Claims

On October 3, 2024 LPRO staff 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).

This 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.

Facility Guidelines Institute: Perspective on Best Practices

The Facility Guidelines Institute (FGI) presented on best practices in structural security in residential behavioral health settings. 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 and 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); and,

- 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.

The Behavioral Health Design Guide *(2022 edition available on OLIS)* is a guidance document for staff safety in facility design and utilizes their "Environmental Safety Risk Assessment Methodology".

Task Force members and presenters discussed weapons screening, including tensions between weapons screening and client rights, and policies in California.

Overview of Current Regulation of Home and Community-Based Facilities

Representatives from DHS and 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 the Code of Federal Regulations (CFR), but are defined in state administrative rules.

Exhibit XX. Home-like Settings and Definitions

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)	APD's Assisted Living Facility (ALF) and Residential Care Facility (RCF) definition of a "home like environment" is *a living environment that*

and Residential Care Facility (RCF) usually serving 6 or more residents per facility.	*creates an atmosphere supportive of a resident's preferred lifestyle, supported by building materials and furnishings*.

Source: Legislative Policy and Research Office

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). They must adhere to federal regulations (CFRs) surrounding individual rights. In addition, state licensing, adult protective service statutes, and administrative rules also apply to these settings.

These 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.

Clients living in these settings also have certain rights. These persons 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 and federal regulations. However, IBL are a "last resort" and must be agreed to by the individual or 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 also provided an overview of how restraint of an individual in a BH setting can be considered abuse, which varies by program.

Exhibit XX. Definitions of Abuse and Use of Restraints, by System of Care

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.* This definition excludes 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 response 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	Under ORS 418, abuse of children in care includes the wrongful use of restraints and involuntary seclusion.	Emergency restraints are allowed in limited circumstances only, and otherwise must be authorized via written order and monitored by a licensed professional (a medical professional, Qualified Mental Health Professional (QMHP), or a Children's Emergency Safety and Intervention Specialist (CESIS) 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.

Source: Legislative Policy and Research Office

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 or 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.

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; and,

- 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); or,
- Secure furniture in individual rooms.

Under current rules, facilities cannot:

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

Under HCBS rules, door locks on staff offices, alarms on doors and windows in common areas, and intervention training for all staff are allowed. HCBS rules do not allow for door locks on private room that would seclude a resident, the use of unauthorized restraints, metal detectors and private room searches, video monitoring in personal areas and other places where care may occur, or the securing of furniture to the floor or wall.

Task Force members and presenters discussed options related to staff safety and HCBS rules, the use of panic buttons, and the relationship of this topic with building codes.

Member Discussion of Priorities for Recommendations

On October 18, 2024, Task Force members discussed their priorities related to physical and structural security.

Task force members began by discussing priorities around physical and structural safety assessments in safety plans. Facilities vary widely in terms of their built environment and options to enhance their structural security. Groups such as FGI suggest that facilities need to assess the security risks and opportunities in their specific context. Currently, behavioral health facilities are not required to have a safety plan that includes a risk assessment of the built environment. Members discussed whether discrete communication devices, such as panic buttons, are considered part of structural security and the need for workers to have a clear process to report structural safety concerns. Members discussed the need for safety plans to be regularly reassessed and a process for employers to address safety

concerns with resident clients when hazardous may develop within or around a private unit. Members also discussed whether safety plans should provide guidance on appropriate use of self-defense when a violent incident arises and when law enforcement should be contacted. The Task Force reviewed information from prior presenters on performing site-specific risk assessments and personal safety enhancements.

The Task Force discussed that often existing behavioral health facilities lack safety-related elements, such as keyless entries or panic buttons. Employers may not have revenue to cover the cost to retrofit facilities with these safety enhancements. Members discussed the Legislative Assembly appropriating funds to support a grant program for behavioral health providers to retrofit existing facilities with these types of safety enhancements. Members also discussed whether there was any existing federal funding available to support these enhancements. Discussion included a need for employers to have access to technical assistance to assess and select from the wide array of product options.

Oregon does not currently require new behavioral health facilities to include safety enhancement elements, such as panic buttons, in the facility's design as a condition to receiving public funds. The Task Force discussed creating a requirement that any newly constructed behavioral health facility include elements to enhance worker safety in the facility design in order to receive state funding. Members discussed this requirement including fixed structural safety enhancements and mobile options for workers who may not be able to access fixed devices. Members noted a need for this requirement to include an enforcement mechanism.

Section 3: Recommendations

On November 14, 2024, the Task Force adopted the XX recommendations presented in this section.[1]

The final recommendations address the following areas:

1. Written safety plans and protocols;
2. Support for employer changes and compliance;
3. Worker rights, reporting options, and trainings; and,
4. Staffing requirements and related payments.

The full recommendations in each of these areas are provided below. They are not presented in any order of priority as Task force members represent a variety of perspectives, and their policy priorities may differ.

Written Safety Plans and Protocols

The Task Force advanced four recommendations related to written safety plans and protocols, provided below.

RECOMMENDATION #1.1: Required Written Safety Plan

The Task Force recommends the Legislative Assembly should direct behavioral health employers to develop 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.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #2.2: Planning for Safety of Lone Workers

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

[1] LPRO staff prepared a list of draft policy concepts based on member discussions of priorities in each domain. The initial list of concepts was presented to the Task Force for discussion on October 18, 2024. Members identified concepts to advance as recommendations. Following that meeting, the draft recommendations were revised and presented to the Task Force for further discussion and public testimony at the November 7, 2024 meeting.

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.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #3.1: Requirement to Assess 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. The built environment may include facilities, vehicles, and other physical locations where work is performed on an ongoing basis. The written safety plan should indicate how workers can report structural security hazards, and the intended time frame for the employer to respond.

OSHA should develop a timeline to phase in this requirement over time, with provider input. OSHA and OHA should publish suggested resources or support options for providers seeking expert consultation on assessments.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #1.3: Enhanced Penalties for Violations

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

See p. XX for analysis related to this recommendation.

Worker Rights, Reporting Options, and Trainings

The Task Force advanced five recommendations to communicate worker rights and reporting options, enhance worker trainings, and ensure protections from retaliation when workers raise concerns. These are provided below.

RECOMMENDATION #1.4: Employer Responsibilities for Safety Trainings

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.
- **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.

Hazard-related trainings should be provided to new hires prior to performing work duties that could expose them to violence. Other trainings should be completed within 90 days of hire. 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 or virtually, with interactive elements. To the extent practicable, other trainings should also be delivered by live instructors, in-person or virtually, and incorporate interactive elements. Employers should minimize reliance on prerecorded content. OHA and ODHS should develop a curriculum and/or list of third-party training curricula that may be used for basic safety training, de-escalation, and workers' rights. OHA and ODHS should employ trainers that can provide these trainings on an ongoing basis for employers who are unable to offer their own trainings to new hires within 90 days.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #1.5: Documentation of Employee Safety Training

Oregon 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.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #1.9: Development of a Critical Incident Template

OSHA should develop a critical incident template for use by behavioral health providers to track "near misses". The form should include a standard definition of "near misses" that is developed with provider input. The form should be simple to fill out and designed to complement an assault log.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #1.10: Log of Critical Incidents

Behavioral health employers should be required to

- maintain a log of critical incidents that meet the OSHA definition of a "near miss,"
- Permit employees to log other incidents that do not meet the definition of a "near miss" but caused worker concern for safety;
- hold "after action meetings" following a critical incident, and
- review critical incidents and assault logs when developing an employer's written safety plan.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #1.11: Reinstatement of Worker Following Retaliation

The Bureau of Labor and Industries may require the reinstatement of an employee, as part of a Final Order, when there is a finding that an employer has unlawfully discriminated and retaliated against an employee due to opposition and complaints related to the Oregon Safe Employment Act (OSEA).

See p. XX for analysis related to this recommendation.

Support for Employer Changes and Compliance

The Task Force advanced six recommendations to support providers becoming and remaining compliant with worker safety requirements. These include potential regulatory changes and financial assistance, and are provided below.

RECOMMENDATION #1.2: Noncompetitive Grants for Support Risk Assessments.

OHA should offer noncompetitive grants to behavioral health employers to support risk assessments (see #3.1) that inform timely development of written safety plans. Grants should be offered up-front to cover employer costs to conduct risk assessments and engage technical advisors as needed. 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.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #3.2: Support for Structural Security Changes

The Legislative Assembly should:

- Appropriate general funds and direct OHA to offer grants to behavioral health providers who have completed risk assessments to retrofit or otherwise enhance existing work settings (e.g. facilities and/or vehicles) with physical

safety enhancements such as keyless entries (e.g. fobs or biometric scanners), communication devices, panic buttons, software, etc.

- Require that any newly constructed behavioral health facilities receiving public funding must complete a physical and structural security assessment and include elements to enhance worker safety in the facility's design.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #1.8: Client Assessment

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.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #xx: Resident Notices

OHA should permit residential or in-home providers to issue a notice to a client when personal belongings are creating a safety hazard for workers and formally request the resident make changes.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #1.6: Agency Rule Making

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 is missing related to 1) assaultive behaviors toward workers, and 2) assaultive behaviors between clients. 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 August 31, 2026.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #1.7: Cross-Agency Coordination

Oregon OSHA, OHA, and ODHS should be directed to increase coordination during 1) enforcement of regulations related to safety of clients and workers, 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.

See p. XX for analysis related to this recommendation.

Staffing Requirements and Related Payments

The Task Force advanced five recommendations related to protecting lone workers and ensuring provider reimbursements support safe staffing levels. These are provided below.

RECOMMENDATION #2.1: Lone Worker Safety Protections

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.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #2.4: Processing Rate Exceptions

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.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #2.5: Payment Models Based on Client Acuity

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

See p. XX for analysis related to this recommendation.

RECOMMENDATION #2.6: Mobile Crisis Team Payment Models

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.

See p. XX for analysis related to this recommendation.

RECOMMENDATION #2.3: Rate Study

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, and
- options for providers to be reimbursed if a second worker must be present to ensure safety of a lone worker.

Findings should be reported to the legislative assembly by December 1, 2025.

See p. XX for analysis related to this recommendation.

Conclusion

The Task Force developed these recommendations over the course of five months and several meetings, hearing from a range of stakeholders and inviting public testimony along the way.

The Task Force respectfully submitted these recommendations to the interim legislative committees on health and requested the Assembly's consideration of these concepts in the upcoming 2025 session.

Appendix A: Needs Assessment

Appendix B: Task Force Workplan

Appendix C: Task Force Presentations and Materials

Table 1 lists the meeting materials made available at Task Force meetings and provides links to those materials posted on the Oregon Legislative Information System (OLIS).

Table 1: Task Force Presentations and Materials