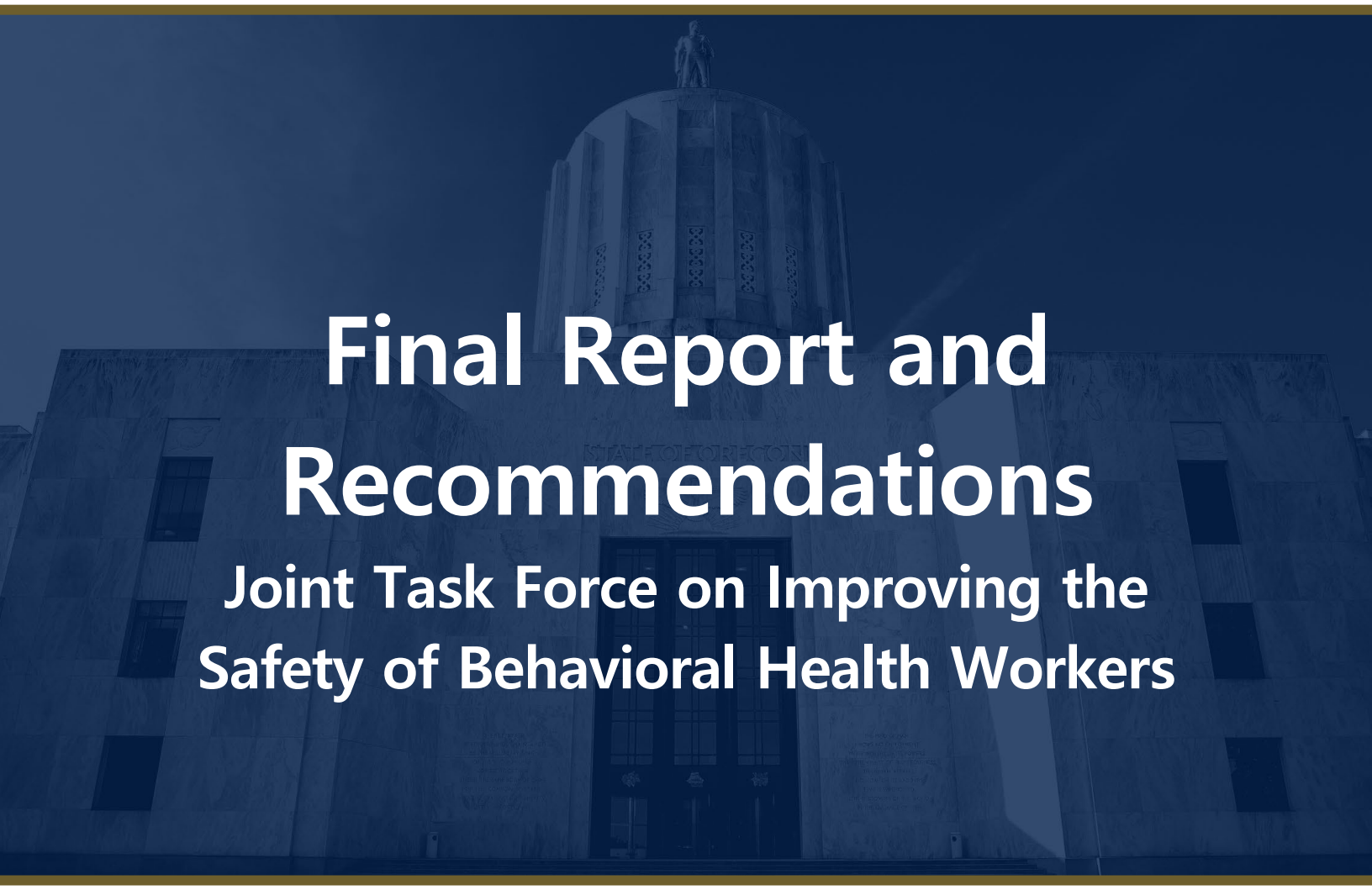

Final Report and Recommendations

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) to 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

Chair: Representative Travis Nelson, House District 44

Vice-Chair: Representative Cyrus Javadi, House District 32

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

Recommendations of the Joint Task Force on Improving the Safety of Behavioral Health Workers

November 20, 2024

The Joint Task Force on Improving the Safety of Behavioral Health Workers (Task Force) was established by the Oregon Legislative Assembly in House Bill 4002 (2024) to address concerns in the behavioral health industry about workers' exposure to violence. The Task Force was directed to develop recommendations addressing employer requirements for safety plans and worker training, physical and structural security, as well as safe 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 proposed changes.

The Task Force consisted of 17 members, including four legislators, 11 community members, and two state agency employees. The membership represented a range of sectors, including behavioral health employers, workers, organized labor, consumers of behavioral health services, Oregon Occupational Safety and Health Division (OSHA), Disability Rights Oregon, and the Oregon State Hospital.

The Task Force's final recommendations address four areas, outlined below.

Written Safety Plans and Protocols

- Behavioral health employers, mobile crisis teams, and emergency shelters should be required to develop written safety plans. Safety plans should address protections for lone workers (including communication in emergencies), an assessment of the employer's physical environment and strategies to mitigate safety risks, as well as the process for safety training, including the training curricula and cadence used by the employer.

Worker Rights, Reporting Options, and Trainings

- Behavioral health employers should be required to provide safety trainings addressing certain topics, including the employer's safety plan, de-escalation techniques, as well as workers' rights and reporting options regarding safety concerns. Some trainings should be required at onboarding and others within 90 days. The employer should be required to document worker trainings.
- Oregon Health Authority (OHA) and Oregon Department of Human Services (OOHS) should develop a list of approved curricula and employ trainers who can provide trainings for employers who are unable to offer their own.

- Employers should be required to document and respond to "near miss" incidents, with support from Oregon OSHA, such as templates and minimum standards for logging critical incidents.
- The Oregon Legislature should permit the Bureau of Labor and Industries to require the reinstatement of an employee 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).

Support for Employer Changes and Compliance

- OHA should offer grants to employers to support risk assessments. OHA, ODHS, and OSHA should publicize technical assistance available to employers.
- OHA should consider physical and structural security elements that promote worker safety and incorporate these in agency rules for behavioral health facilities.
- The Legislative Assembly should resource OHA to offer grants to behavioral health providers to retrofit or augment existing work settings with physical safety enhancements. Any newly constructed behavioral health facilities receiving public funding should be required to include elements to enhance worker safety in its design.
- OHA rules should permit a provider to consider a client's full history when determining suitability for admission. OHA and ODHS should also study whether residential or in-home providers may issue a notice to a client when personal belongings are creating a safety hazard for workers and formally request the resident make changes.
- Oregon OSHA, OHA, and ODHS should review perceived tensions between agency rules for client and worker safety and develop related guidance for employers. The agencies should increase coordination during enforcement of these regulations.

Staffing Requirements and Related Payments

- Behavioral health employers should offer a communication device to any worker who may be alone with a client or allow the worker to request a second person be present during a patient visit.
- OHA should analyze and consider in future rate development the following: 1) the cost of raising the minimum staffing requirement for behavioral health facilities to two workers and 2) the cost of structural security enhancements or safety planning policies. OHA should also reduce processing times when providers request a rate exception and develop a fast- track option when a client's behavior rapidly changes.
- OHA should 1) require CCOs to use payment models that support two-person mobile crisis teams, and 2) reimburse providers for crisis services to people without coverage.
- The Department of Consumer and Business Services should study how carriers could include mobile crisis intervention as a covered service in commercial health plans.

The full report can be found online at https://olis.oregonlegislature.gov/liz/2023I1/Committees/JTFBHW/2024-11-14-13-00/MeetingMaterials.

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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 appointed by the Speaker of the House and Senate President, including four legislators and 11 community representatives, 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 the 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 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 three policy domains outlined in House Bill 4002: 1) safety plans and protocols, 2) staffing levels, and 3) physical and structural security.

Members identified certain **near-term goals** for their work:

- 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 1). 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.

Exhibit 1: 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 • 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) • 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) • layout of buildings or settings (sight lines, escape needs and escape routes)

Source: Legislative Policy and Research Office

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

Preliminary Report on September 1, 2024

By September 1, the Task Force was responsible for submitting to the interim committees of the Legislative Assembly related to health, 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 meetings focused on organizational tasks such as election of chair and vice-chair; review of the needs assessment; and scoping the policy domains. One meeting focused on the legislative history that led to the creation of the Task Force in HB 4002.

The preliminary report provided an update on the work of the Joint Task Force on Improving the Safety of Behavioral Health Workers because the Task Force did not have enough time to develop draft policy recommendations for inclusion in the preliminary report. The preliminary report included information regarding the background and charge of the Task Force, its membership, initial assessment and planning discussions, as well as the 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.

Section 2: Analysis of Policy Options

The Task Force considered unmet needs and potential policy options in three domains (see Exhibit 2):

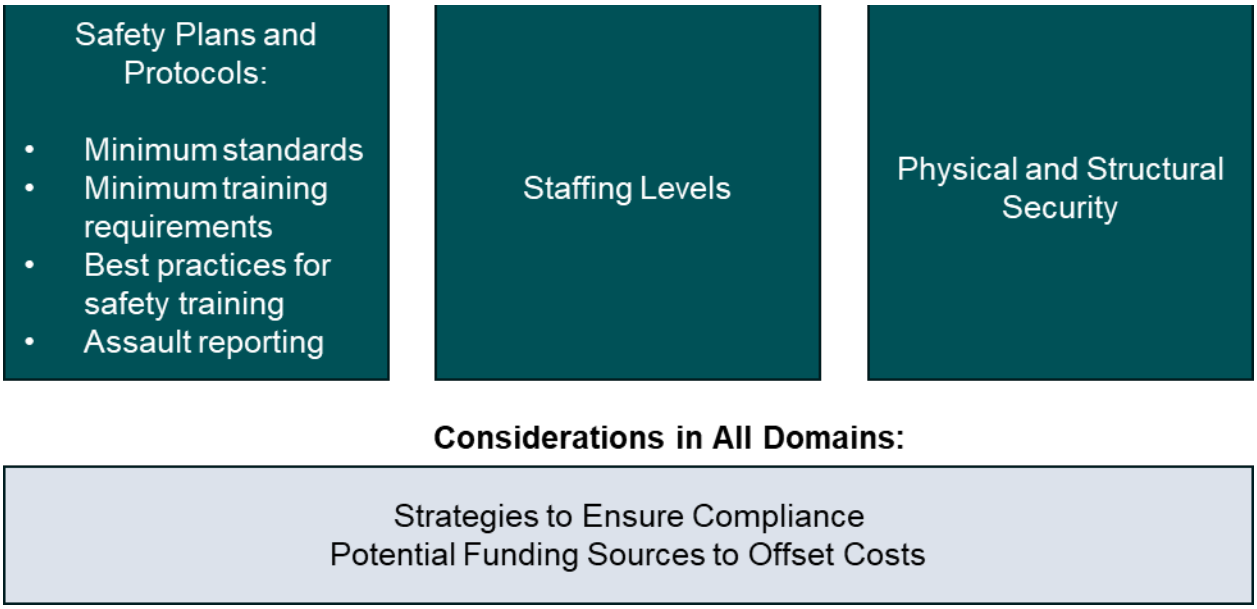
1. Safety Plans and Protocols
2. Staffing Levels
3. Physical and Structural Security

Within each domain, members 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 2. 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.
- 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, the agency is 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 3 below.

Exhibit 3. 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 the following entities: • 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 • establishments primarily providing housing Hospital and surgical center employers are required to do the following: • 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 program 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. Maintain an assault log, which is a critical input to planning by the employer and the employer's 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

Provider Type	Statutory Requirements
	• Employers shall "furnish employment and a place of employment which are safe and healthful for employees" Because this requirement 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." • 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:

- 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.
- A home health worker has the 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 the following:

- security/silenced alarm systems,
- exit route,
- 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:

- the 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 TJC is an independent, not-for-profit organization that accredits and certifies health care organizations. TJC 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. Behavioral health organizations accredited by TJC 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 with the following components:

- 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.

To receive accreditation by the TJC behavioral health organizations must meet the following standards:

- **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 [their] workplace violence prevention program" and take action to mitigate or resolve based on findings of the assessment.

- **Monitoring:** Organizations must also have a process to collect data to continually monitor, internally report on, and investigate safety and security incidents.
- **Training:** Organizations must provide training, education, and resources on workplace violence prevention programs at the time of hire, annually, and whenever changes occur.

Accredited organizations develop 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:

- 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 suggests 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 accredits, consequences when a facility does not meet the required standards, and the 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 as well as 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).
- 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 the following steps:

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.
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 reflected upon

- the need to distinguish between de-escalation trainings and safety trainings;
- the need to develop trainings that are appropriate to a work setting and environment;
- the value of different types of trainings, such as virtual, in-person, and train-the-trainer models; and
- the importance and feasibility of de-escalation trainings occurring upon hire and at regular intervals.

Members considered

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

Further, Task Force members noted

- employer and employee experiences with tensions complying with existing Oregon OSHA rules for worker safety while also complying with OHA/DHS rules for client care,
- 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 then reviewed 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. In response, members considered 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;
- challenges with imposing new requirements through OHA/DHS because these settings are regulated through different pathways, if at all;
- whether expanding safety plan requirements beyond hospitals to other settings was appropriate given the different size and capacity of community-based settings;
- the possible need for enhanced technical assistance to help employers in complying with existing OSHA rules; and
- other options for increasing awareness of existing safety rules among employers and employees.

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 defined as employees who

- work 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
- 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 approaches to mitigate safety risks specific to individuals working alone. 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 for lone workers. However, there are some federal industry-specific policies for addressing shipyard workers (OSHA 1915.84), confined space entry (OSHA 1915.84), hazardous waste, and emergency response (OSHA 1910.120).

Although lone worker policies in the health care setting are not commonplace in the US, these strategies are 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, as well as 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, those who interact with those lone workers, and those who may be involved in the actions outlined in the policy.
- **Training:** Employers are required to provide training and to identify each employee's training needs as a component of risk assessment.
- **Support:** Following an incident or a "near miss," related to violence or aggression, there must be a system to respond, such as investigation and adapting systems to better prevent the situation from happening in the future, providing information on counseling, and liaising with law enforcement as necessary.

Washington State SHB 1456 (2007) is 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.

SHB 14562 includes these key components:

- 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, as well as prevents retaliation for refusal to go to a home visit alone following consultation with a clinical team.
- Requires wireless communication devices for staff responding to private locations.

- Requires DMHP and crisis service providers to maintain a written policy covering training, staffing, information sharing, and communication for staff responding to private locations.
- Requires prompt access to patient histories.
- Requires annual worker training on safety and violence prevention.

There was a prior version of this bill which included mandatory staffing minimums (specifying a second DMHP staff member). However, it stalled in the Washington 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 from the General Fund was $2,021,000 in 2008 and $1,683,000 in2009.

A train-the-trainer curriculum was developed by a steering committee representing a diverse group of stakeholders. 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 and conveyed to the Task Force implementation information from Washington SEIU (1199nw). This federation noted 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 approach 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, 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 when a behavioral health worker felt unsafe during a house visit where they were working alone. Although they had advocated for a second person with clinical training, the process was ongoing and has yet to be resolved. In this example, the employee has 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.
- **Risk corridors,** temporary financial arrangements established when there is uncertainty about the potential costs or utilization for a new covered service, 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 the following:

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

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

- **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.
- **Inpatient psychiatric** stays are paid a base rate developed from modified Diagnosis-Related Groupings (DRG) with additional per diem amounts after 30 days.

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.

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

Exhibit 4. 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

Provider	Payment Methodologies
OHP Fee-for-service	• OHA compared Medicaid and Medicare reimbursements in early 2024 • OHA's goal is to pay 80% 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 licensing behavioral health facilities. The agency 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 5. 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

Provider Type	Maximum Capacity	Minimum Staffing
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:

- OHA continues to seek input on rate redesign as the agency works 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. The agency is also implementing a new functional needs assessment tool to address known limitations of the LSI tool that does not adequately capture medical complexity or safety risks for clients with behavioral health conditions.
- OHA is piloting a questionnaire for hospital and CMHP staff to ensure clients are directed to the appropriate agency (OHA or ODHS) for needs assessments. This is intended to reduce duplication of assessment work, ensure timely completion of eligibility determinations, and improve referral timelines to HCBS. During this meeting, 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.

Task Force members noted the following issues around lone workers:

- 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.
- Workers need to be trained or provided notice on lone worker policies as well as the right to refuse work in unsafe environments.
- Should workers be able to request a second worker when performing certain duties?
- What is 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.
- A potential increase to minimum staffing requirements could cause challenges, such as requiring workers to take additional shifts, given current workforce shortages.
- Alternatives to increasing staffing requirements including de-escalation training and self-defense training.

Members also discussed issues around OHA's FFS 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 an FFS approach that does not cover the cost of maintaining two-person teams consistently 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 an 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.

- 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 that 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)
- *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, as well as 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 they are defined in state administrative rules (see Exhibit 6).

Exhibit 6. 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) and Residential Care Facility (RCF) usually serving 6 or more residents per facility.	APD's Assisted Living Facility (ALF) and Residential Care Facility (RCF) definition of a "home like environment" is *a living environment that creates an atmosphere supportive of a resident's preferred lifestyle, supported by building materials and furnishings*.

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 three 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 an 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 behavioral health setting can be considered abuse, which varies by program.

Exhibit 7. 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	• 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. • Physical restraints 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

System	Definition of Abuse	Use of Restraints
	• less restrictive alternatives have not first been considered • the restraint is used for convenience or discipline	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 are permitted only in licensed secure inpatient programs (child and adolescent) only as a last resort by a qualified professional.

System	Definition of Abuse	Use of Restraints
		• 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 the priorities related to physical and structural security.

- 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.
- Are discrete communication devices, such as panic buttons, considered part of structural security?
- Workers need to have a clear process to report structural safety concerns.
- Safety plans need to be regularly reassessed.
- A process for employers to address safety concerns with resident clients when hazardous may develop within or around a private unit.
- Should safety plans 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 and went on to discuss the following considerations:

- 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.

- Could the Legislative Assembly appropriate funds to support a grant program for behavioral health providers to retrofit existing facilities with these types of safety enhancements?
- Is there existing federal funding available to support these enhancements?
- Employers need 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 should include

- elements to enhance worker safety in the facility design to receive state funding,
- fixed structural safety enhancements and mobile options for workers who may not be able to access fixed devices, and
- an enforcement mechanism.

Section 3: Recommendations

On November 14, 2024, the Task Force adopted the recommendations presented in this section with 12 aye, 0 nay, and one excused votes.[1]

The 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
4. Staffing Requirements and Related Payments

The full recommendations in each of these areas are provided below. Recommendations 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 three recommendations related to written safety plans and protocols.

RECOMMENDATION: Required Written Safety Plan

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.

See p. 14 for analysis related to this recommendation.

RECOMMENDATION: 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 additional discussion and public testimony at the November 7, 2024 meeting. The recommendations were further revised and presented to the Task Force for adoption at the November 14, 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. 24 for analysis related to this recommendation.

RECOMMENDATION: 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. 32 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.

RECOMMENDATION: 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, Oregon OSHA, or other entities.

The employer's written safety plan should identify which curricula are selected to meet these requirements, the timeline for a new employee to complete the training, and how often the trainings should be renewed or refreshed for existing workers.

The following content should be provided to new hires at onboarding prior to performing work duties that could expose them to violence: emergency procedures, an overview of the written safety pan, emergency communications/devices, and how to report a safety concern or violation. Other trainings should be completed within 90 days of hire.

OHA and DHS shall develop a list of approved third-party training curricula that may be used for basic safety training, de-escalation, and workers' rights. The list should include a schedule of training recurrence based on the recommendation of the curriculum developer, but no less than every three years. OHA and DHS may also develop curricula. OHA and DHS 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. 14 for analysis related to this recommendation.

RECOMMENDATION: 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 lead workers in practice or "drills" of training content. Oregon OSHA should impose penalties when employers do not comply.

See p. 14 for analysis related to this recommendation.

RECOMMENDATION: Development of a Critical Incident Template

OSHA should develop minimum standards for employers to track "near miss" critical incidents. The agency should develop a sample log for provider use that includes a standard definition of "near misses" developed with provider input. The form should be simple to fill out and designed to complement an assault log.

See p. 14 for analysis related to this recommendation.

RECOMMENDATION: 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," using either the OSHA-developed template or the provider's own template that meets minimum standards,

- 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. 14 for analysis related to this recommendation.

RECOMMENDATION: 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. 14 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.

RECOMMENDATION: 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. 14 for analysis related to this recommendation.

RECOMMENDATION: Support for Structural Security Changes

The Legislative Assembly should

- direct OHA to consider physical and structural security elements that promote worker safety and incorporate these in agency rules for behavioral health facilities,
- appropriate general funds and direct OHA to offer grants to behavioral health providers 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. and,

- require that any newly constructed behavioral health facilities receiving public funding must include elements to enhance worker safety in the facility's design.

See p. 32 for analysis related to this recommendation.

RECOMMENDATION: 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. 14 for analysis related to this recommendation.

RECOMMENDATION: Resident Notices

OHA and DHS should study whether federal rules and Oregon's Medicaid waivers 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. If this is permissible, the agencies should update rules to permit this.

See p. 14 for analysis related to this recommendation.

RECOMMENDATION: 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.

The Legislative Assembly should amend ORS 654.423 to apply to the following facilities, in addition to those named in ORS 654.412(3): residential treatment facilities (ORS 443.400), secure RTF (ORS 443.465), health care facilities (ORS 442.015), sobering facilities, detox centers, and halfway houses (ORS 430.306), mobile crisis (OAR 309-072-0110), and emergency shelters. This change is intended

to permit workers in these settings to use physical force as self-defense against assault without fear of disciplinary action.

[Note: This recommendation does not propose to expand the settings subject to ORS 654.412 through ORS 654.421.]

See p. 14 for analysis related to this recommendation.

RECOMMENDATION: 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, 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.

See p. 14 for analysis related to this recommendation.

Staffing Requirements and Related Payments

The Task Force advanced six recommendations related to protecting lone workers and ensuring provider reimbursements support safe staffing levels.

RECOMMENDATION: 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. 24 for analysis related to this recommendation.

RECOMMENDATION: 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. 24 for analysis related to this recommendation.

RECOMMENDATION: 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. 24 for analysis related to this recommendation.

RECOMMENDATION: Mobile Crisis Team Payment Models

The Legislative Assembly should direct and provide resources to OHA to:

- require CCOs to use prospective payment models that support two-person mobile crisis teams.
- Provide funding to mobile crisis providers for services to people without behavioral health coverage.

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. 24 for analysis related to this recommendation.

RECOMMENDATION: Commercial Carrier Coverage Study

The Department of Consumer and Business Services should study options to require commercial carriers to include mobile crisis intervention as a covered service in commercial health plans. Coverage of mobile crisis services should be offered without cost sharing or co-pays. The agency should report findings to the Legislative Assembly by December 1, 2025.

See p. 24 for analysis related to this recommendation.

RECOMMENDATION: 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, and
- 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. 24 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 submits these recommendations to the interim committees of the Legislative Assembly related to health and requests the Assembly's consideration of these concepts in the upcoming 2025 session.

Appendix A: Needs Assessment

See next page.

Memorandum

PREPARED FOR:
Chair Nelson and Members of the Joint Task Force
On Improving the Safety of Behavioral Health Workers
DATE: July 23, 2024
BY: LPRO Staff
RE: Needs Assessment – Results Summary

The Joint Task Force on Improving the Safety of Behavioral Health Workers (JTFBHW) was established through House Bill 4002 (2024) to develop recommendations for the legislative assembly. Prior to its first meeting, JTFBHW members were surveyed to gather preliminary information. This memorandum contains a qualitative summary of responses from members to inform initial planning and scoping conversations.

This summary offers a snapshot of *individual* ideas, priorities, and needs identified by Task Force members. These views have not yet been discussed by the group and do not reflect consensus of the group on any matter. Official recommendations of the Task Force will be developed at a later date.

Vision for the Task Force's Work

Members offered a wide range of perspectives on what success will look like for this group's work. Members reported thinking about these **dimensions of success:**

- near-term and longer-term outcomes to aim for,
- process or steps the group should take in its work, and
- initial priorities for potential recommendations.

Near- and Longer-Term Outcomes of Interest

Members articulated the following **near-term outcomes** they would like to see the group achieve. These include

- **Changes in awareness and knowledge.** This included identifying best practices, ensuring all parties have increased understanding of different facility types and how they would be affected, while also recognizing potential unintended consequences of existing or proposed policy changes. For example, one member noted that stricter provider regulations can lead to providers denying admission of higher acuity individuals.
- **Changes in policy.** This included issuing a comprehensive report with actionable steps for legislative action in 2025 and a roadmap for legislative investments to support recommendations (particularly proposed mandates). It also included proposals for new strategies that could be incorporated into agency administrative rules.

Some members also articulated **long-term outcomes** that they felt should guide Task Force planning. These included

- measurable reductions in violent incidents over time,
- increasing worker safety without increasing unnecessary litigation or criminal charges against health care consumers,
- an accountability framework to ensure employer compliance, and
- Oregon Health Authority, Oregon Department of Human Services, and Coordinated Care Organizations sharing greater responsibility with providers for worker safety.

Goals for Process

Members identified several **steps to be addressed** in the work and goals for how those steps could be approached. See Exhibit 1 below.

Exhibit 1. Member Perspectives on Task Force Process

Steps	Goals for This Step
Group Communication	• a clear project charter, shared goals and objectives, and agreed-upon approach • effective time management and regular check-ins • established communication norms, including a process for resolving major disagreements and guidelines for giving feedback • realistic expectations for collaboration
Scoping the Conversation	• initial scoping focused on potential settings • consideration of existing regulations
Analyzing Causes of Workplace Safety Risks	• acknowledge the issue's complexity and dynamism • identify specific causes of violence and develop targeted responses • evaluate existing statutes and rules affecting provider safety, and propose revisions • gather frontline worker input on safety needs; ensure stakeholder interests are considered
Prioritization and Decision-Making	• identify workers most at risk or rank risk types by setting • focus on highest-risk, most challenging problems; address other issues through standard processes • make decisions based on majority vote
Develop Recommendations and Identify Resources	• Develop practical, evidence-based recommendations focused on the highest-risk areas and most challenging problems. Prioritize common-sense safety measures that promote safety without discrimination or over-restriction. • Establish measurable and achievable goals with concrete, practical recommendations for providers across settings.

- Address governance, oversight, and operations, balancing agency and program responsibility for safety.
- Set reasonable implementation timelines and identify funding for mandated actions, including resources for statewide training.
- Hold agencies and Coordinated Care Organizations (CCOs) accountable for building care systems for high-acuity clients, including dedicated beds for substance-use disorder clients.
- Provide adequate resources for employers and regulatory agencies, as well as for employers and employees to reduce violence incidents.

Source: Member Responses to Needs Assessment, July 2024

Initial Member Priorities

Members were asked which topics were their highest priority for focus. The following were identified by one or more members as their priorities:

- **Structural security improvements,** including security technology matched to the level of care provided in each setting.
- **Improving assessments and placements** through better matching clients based on level of care needed rather than available openings; improving options to discharge clients whose behavior becomes dangerous; and establishing a pathway to involuntary commitment for people whose behavior is dangerous due to substance use (e.g., Washington State's "Ricky's Law").
- **Training and resources** that are widely available to employers and workers and focused on reducing injuries from violence.
- **Documentation and information exchange standards that** improve the way assaults are tracked so providers have access to documentation and client histories and the ability to exchange information across settings.
- **Staffing changes**, including ensuring employees do not have to work alone and that providers have emergency plans and resources to maintain safe staffing levels during workforce shortages.

Scoping the Task Force's Work

Defining Workplace Settings

In general, there was agreement with the starting list provided in the questionnaire. Exhibit 2 below includes this list along with 1) additional settings proposed with no apparent disagreement among members, and 2) additional settings proposed where there are divergent opinions among members.

Exhibit 2. Potential Settings for Task Force Consideration

Initial List (from SB 1594-introduced)	• Residential treatment facilities (as defined in ORS 443.400) • Secure residential treatment facilities (as described in ORS 443.465) • Health care facilities (as defined in ORS 442.015) • Sobering facilities, detoxification centers and halfway houses (as those terms are defined in ORS 430.306)
Additions Suggested by Members *** indicates some members supported addition while others opposed*	• Behavior rehabilitation services (children's group homes) • **Community-based care (mobile crisis, street outreach, etc.) for people who are experiencing homelessness • Criminal justice system services • Group homes for adults and children with intellectual and developmental disabilities (IDD) • **In-home care • Medical clinics that function primarily to provide behavioral health care • Memory care (e.g., nursing homes with memory care designation) • **Mobile crisis intervention teams (as defined in OAR 309-072-0110) • Psychiatric facilities • **Supportive housing • "Missing levels of care" not reflected in current continuum

Source: Member Responses to Needs Assessment, July 2024

One member noted the need to consider **how behavioral health care settings vary**, including by

- type of services and level of care offered,
- acuity of clients,
- safety capabilities of the physical site, and
- ability to make safety upgrades if the building is not owned by the agency (e.g., a county or government building).

One member noted that the Task Force should **be aware** that BH employees work in settings such as schools or settings not primarily involved in the delivery of health services. Members should be mindful of how recommendations do or do not address these employees. Another member noted that strategies for facility-based care are likely to be very different than for community-based or mobile care and suggested focusing the Task Force's work on the former. Another member suggested the Task Force be mindful of missing levels of care that are causing clients to be referred to settings that are not matched to their needs.

Defining Behavioral Health Workers

Members held **divergent opinions** on whether to include non-clinical workers in the Task Force's scope.

Several members indicated that **all workers, not just clinicians**, can be affected by workplace violence. Many roles such as administration or maintenance can have client contact even if they do not provide direct care. Others can be bystanders to violent encounters targeting clinicians. De-escalation training would be valuable in all cases. One member noted that as a practical matter, employers likely need to consider all workers, and there may be limited value in restricting the scope of recommendations to clinicians.

In contrast, other members answered that **client-facing roles** should be the priority focus of the Task Force's work due to the increased risk of violence these individuals may face from more frequent client contact. One member noted that the focus should not be limited to licensed or certified behavioral health clinicians, since this could exclude non-licensed clinicians who work in drug and alcohol rehabilitation centers accredited by the Council on Accreditation (COA).

Other comments included

- three members who specifically requested to include **lobby staff** such as security or front desk workers who may be "front line staff" in safety situations,
- two members who specifically requested to include **janitorial staff** given that they can spend much of their time in client areas, and
- one member who noted that rather than adopting an inclusion/exclusion lens with respect to specific roles, the Task Force could consider a **primary/secondary/tertiary lens** that prioritizes roles based on risk of violence.

Defining Safety Risks

Most members responded that **workplace violence** should be the primary focus for the Task Force, given the group's short timeline. Members' responses to the needs assessment questions focused primarily on this area.

Environmental hazards were also identified by several members as an important secondary issue with several connection points to risks of violence.

Some members felt that other safety risks such as **bloodborne pathogens or ergonomic injuries** were well addressed by existing standards and the Task Force should exclude them from its focus.

Workplace Violence

Members identified examples of **workplace violence risks** where the Task Force could focus its efforts. These included situations where

- facilities accept a client who is later identified as having higher needs than the facility can safety address,
- mandated de-escalation steps such as Crisis Prevention Institute's Non-Violent Crisis Intervention (CPI-NCI) approach are not effective,
- weapons (including knives and household items) are present,
- animals (such as aggressive dogs) may pose safety threats,
- law enforcement or first responders take command in an encounter with a client.

Environmental Risks

Members identified several environmental risks that could be addressed for BH workers. These included

- **Natural disasters and disaster preparedness training.** For example, mobile crisis and community outreach workers can face exposure to wildfire smoke, hazardous conditions driving in snow and ice, etc. Providers may need standards for whether mobile crisis teams will respond in-person in certain situations, such as entering an evacuation zone during a wildfire.
- **Working in areas with limited connectivity.** One member noted that this can pose danger if an employee has limited options to call for help.
- **Chemical and other hazardous exposures.** Members noted that BH workers can be exposed to substances (e.g. fentanyl smoke or other drugs); pests (e.g. bed bugs, mice); bodily fluids; mold; and cleaning products or sanitizers that pose environmental hazards.

Domain 1: Physical and Structural Security

Members were asked to identify specific needs and opportunities related to the physical or structural security of settings where behavioral health care is provided. Members identified **three areas** with needs or opportunities related to physical/structural security:

- programs and systems for monitoring staff safety,
- structural elements, and
- physical design or layout of BH settings.

These ideas are not specific to certain provider types. See Exhibit 3 (next page).

Two members noted that many behavioral health settings are often older facilities that were not purpose-built or were not designed for clients with the levels of acuity currently being served. This can include group homes, as well as halfway or transitional housing

sites. One member noted these facilities often have substantial deferred maintenance or capital needs that the Task Force should be aware of.

Exhibit 3. Needs and Opportunities Related to Physical/Structural Security

Physical/Structural Security Elements	Needs and Opportunities to Improve Safety
Programs and Systems for Monitoring Staff Safety	• Communication devices for staff that support requesting immediate assistance (e.g., walkie talkies, intercoms, alert or panic buttons) • Supervised security cameras in common areas with recordings that can assist in incident investigation • Surveillance software
Structural Building Elements	• Double paned windows with secure glass • Walls that cannot be punctured (e.g. to access plumbing) • Secure doors with working locks or push-bar openings • Secure staff offices • Kitchens with locking or secure storage • Anti-ligature plumbing fixtures, closet rods, doorknobs • Secure or affixed furniture
Physical Design or Layout	• Clear sight lines without blind corners • Staff offices with visibility into patient areas • Open spaces that enable evasion tactics • Avoiding “dead-end” spaces without escape routes

Source: Member Responses to Needs Assessment, July 2024

Additionally, members identified structural/physical needs and opportunities that were specific to certain settings. These include

- **Oregon State Hospital.** One member noted OSH was not purpose-built for a forensic population with high risks of violent behavior. In addition to physical design issues identified above, OSH buildings do not have capacity to support the size of population that needs its services. There is a shortage of single occupancy rooms (which is problematic particularly for patients who cannot have roommates because of a history of violence or sexual assault). Opportunities, which would need legislative approval, include 1) converting double rooms to single occupancy; 2) adding more seclusion rooms; and building another facility (ideally in central or eastern Oregon) to accommodate patients from those areas.
- **Mobile crisis teams.** One member noted that there is a need for all-wheel drive vehicles for these workers.

Domain 2: Safety Protocols and Procedures

Members were asked to identify specific needs and opportunities related to safety protocols and procedures in settings where behavioral health care is provided. Members' responses related to **four aspects of safety protocols**:

- the need for templates and sample policies,
- specific contents that should be included in employer policies,
- tensions that need to be balanced in client safety plans, and
- new or enhanced training needs.

These are described in more detail in Exhibit 4 below.

Exhibit 4. Needs and Opportunities Related to Safety Protocols

Protocol Elements	Needs and Opportunities to Improve Safety
Templates and Sample Policies	• Standard Operating Procedures (SOP) • Standard formats for behavior safety plans for clients • Requirements that promote standardization and consultation
Content of Employer Policies	• Communication protocols, including guidance on how to call for help (other than 911) or take other safety steps that will not result in accusation of abuse or neglect • Guidance on allowable client personal belongings • Guidance for providers when an individual cannot be safely managed within its programs • Protocol for assaults, including steps for reporting, reviewing/investigating incidents, and tracking incidents (including "near misses") over time
Client Safety Plans	• Access to records that allow providers to evaluate the acuity level of clients and risks of violent behaviors • Behavior plans that are readily available to staff working with clients • Balancing between clients' rights and the need to maintain the safety of workers

Safety Training	• Offer statewide trainings focused on safety; standardize trainings
	• Cover specific training topics
	  ○ relationship between staffing levels and risks of violence
	  ○ coordination with law enforcement
	  ○ field safety, including how to safely drive and transport clients
	  ○ de-escalation and evasion
	• Design trainings for specific audiences including 1) mental health therapy aides, 2) nursing staff, and 3) mobile crisis teams
	• Revisit options for de-escalation training (Pro-Act, CPI-NCI). Allow selection from an approved list rather than mandating a specific selection.
	• Design promotion pathways for aides who complete training and demonstrate proficiency (e.g., Alaska Psychiatry Institute).

Source: Member Responses to Needs Assessment, July 2024

Domain 3: Safe Staffing Levels

Members were asked to identify needs and opportunities to address safe staffing levels in settings where behavioral health care is provided. Member responses addressed four areas including:

- minimum staffing levels,
- paying for staffing,
- staffing contingency plans, and
- specific roles needed.

Further details from members' comments are provided in Exhibit 5 below.

Exhibit 5. Needs and Opportunities Related to Staffing

Staffing Elements	Needs and Opportunities to Improve Safety

Minimum Staffing Levels	• DHS and OHA guidance needed on minimum staffing levels
	• Potential minimum requirements could include
	  ○ Staff should not work alone; minimum of two staff on overnight shifts and increased staffing on evenings and weekends
	  ○ Different minimum staff-to-client ratios for acute and subacute levels of care. For example: acute care (weekdays 1:5; evenings/weekends 1:3; overnight 1;6) versus sub-acute (weekdays 1:10; evenings/weekends 1:6; overnight 1:10).
	• Minimum staffing ratios should account for varying client acuity or level of care needed, including specific expectations for staffing levels when facilities accept clients with a history of violence.
	• Minimum staffing ratios must be achievable within the context of the larger workforce shortage.

Paying for Staffing	• Provider budgets are set to meet minimum staffing levels. OHA and ODHS rate structures need to account for safe staffing levels or new minimum requirements • Clarity is needed on who pays for 1:1 or 2:1 staffing when clients cannot be safely managed in a normal milieu • Providers need a process to immediately negotiate reimbursement changes if a client at/after admission is determined to need a higher level of care. This should not be a 30-day negotiation process. • Providers need funding to offer competitive wages

Contingency Plans	• If new staffing minimums are imposed, providers need guidance on how to address situations where
	  ○ They are unable to maintain minimum staffing levels (e.g., when to freeze admissions or transfer clients),
	  ○ No staff are able or willing to work with a client with a history of violence,
	  ○ A client needs a higher level of care (e.g., how to rapidly discharge or transfer to another setting), and

	• Payers should not pressure providers to accept higher acuity clients than they can care for.

Specific Staffing Needed	• Staff will be needed to monitor new security camera feeds
	• Employers need sufficient maintenance staff to quickly address repairs to physical safety elements
	• Oregon State Hospital specifically needs
	  ○ Increase in staff per unit from 12 to 14 during day/swing shifts,
	  ○ Increase in psychiatric staff, and
	  ○ 12-hour shifts for nurses to increase consistency and coverage during day/swing shifts, reduce transitions. Flexibility is needed to offer a 36-hour work week to match this staffing model.

Source: Member Responses to Needs Assessment, July 2024

Several members identified workforce challenges that exacerbate safety risks. BH positions can commonly require evening or weekend work, with few options to work from home. Members noted that high-risk positions can be harder to fill or retain. One member noted that until sector-wide workforce shortages are addressed, expectations on BH workers may need to be more flexible.

Supporting Implementation and Compliance

Members were asked what the Task Force should consider in support of implementation of its recommendations. Members requested that the Task Force consider **how to support implementation** of recommendations, including:

- the feasibility of changes for workers and employers,
- how physical upgrades could impact access to care or service delivery (e.g., requiring reductions in census during remodels),
- what timeline for changes may avoid excessive strain on existing programs,
- how these issues relate to other conversations about behavioral health workforce hiring and retention, and
- where and how to offer grace periods during implementation of changes.

The Task Force should consider what is known about best practices as it develops its recommendations. The state may need to take certain **steps to ensure compliance** with any desired changes in BH settings, such as

- requiring employer documentation of new procedures,
- demonstrating that information has been incorporated in employee orientations or trainings,
- demonstrating that employees have access to safety information,
- tying state funding to compliance with new requirements, and
- imposing penalties for not having appropriate documentation.

These requirements may need to be codified in agency administrative rules.

Other members noted the importance of **listening to providers' concerns** about their ability to implement new requirements. One member requested the Task Force avoid recommending staffing mandates that providers would be unable to comply with due to workforce shortages. Another member noted the importance of listening to providers' concerns about existing regulations before holding them accountable for new ones. A third member noted the need for clear policies regarding whether providers are responsible for client behaviors when a facility has already indicated they cannot safely maintain the individual.

Members requested that the Task Force consider **what resources are needed** to operationalize its recommendations across different settings. Several members noted the importance of identifying funding options for 1) staffing, with consideration for how provider reimbursements influence provider ability to hire staff, 2) workforce incentives such as hiring or retention bonuses or student loan forgiveness, 3) state oversight of compliance, and 4) trainings to support providers coming into compliance.

These suggestions included

- identifying funding sources for specific recommendations where possible,
- recommending awards processes that tie funds to specific desired outcomes, and
- recommending processes for monitoring funding to ensure resources are used as intended and produce the expected results over time.

Task Force Needs

Members were asked what would help the group develop its recommendations. Members identified several types of information or resources that would be helpful, including the following:

- **Exemplary models and best practices.** Members requested to learn about exemplary models in Oregon or other states. Which organizations (hospitals, clinics, residential programs) are leading on safety issues and what has worked in those settings? What tools already exist? What are examples of facilities built to higher standards? What are Recognized and Generally Accepted Good Engineering Practices (RAGAGEP) for industries?
- **Expert recommendations.** Members requested to hear from subject matter experts, including:
    - the International Association for Healthcare Security and Safety,
    - Oregon and federal Occupational Safety and Health (OSHA),
    - Oregon Department of Human Services,
    - the National Institute for Occupational Safety and Health (NIOSH)
    - Professional Associations, and

    - Experts in RAGAGEP and industry-specific standards and best practices.
- **Hearing from providers and workers.** Members requested to directly ask workers and providers about their needs, either by inviting them to speak to the Task Force or surveying them about barriers to safety and any ideas for improvement. One member requested to survey providers by region.
- **Policy scan.** Members requested to learn about existing laws or regulations that could be updated to incorporate new requirements.
- **Cost estimates.** Members requested guidance on what level of new investments the legislature may approve, as well as economic advice on costs for various proposals.

About this Document

This document was prepared by the Legislative Policy and Research Office (LPRO). LPRO provides centralized, nonpartisan research and issue analysis for Oregon's legislative branch. LPRO does not provide legal advice. LPRO publications contain general information that is current as of the date of publication. Subsequent action by the Task Force may affect accuracy.

LPRO surveyed members in June 2024 using a written questionnaire. Ten members responded. LPRO analyzed responses using an inductive qualitative coding approach. Content was thematically organized to highlight areas of agreement or disagreement in the group. This analysis summarized content for brevity but did not rank or prioritize content for inclusion and aimed to reflect the full range of responses.

LPRO has not independently verified the accuracy of any claims in this document and as a nonpartisan agency has no position on the merits, appropriateness, feasibility, or potential impact of any ideas expressed herein.

Appendix B: Task Force Workplan

See next page.

TENTATIVE 2024 WORKPLAN

PREPARED FOR: Joint Task Force on Improving the Safety of Behavioral Health Workers
DATE: July 31, 2024
BY: LPRO staff

This draft workplan provides information on upcoming meeting dates, decision milestones, and planned topics. All agenda items are tentative and may change depending on availability of guest speakers or information, Task Force discussion, and Chair discretion. This document is current as of the date above; please check with LPRO staff for the most current version.

Month	Focus	Topics and Tasks	Additional Resources

July 18, 2024 [done]	*Getting Started*	• *Welcome/Introductions*
		• *Adoption of Task Force Rules & Review Operating Procedures*
		• *Review of House Bill 4002 and Task Force charge*
		• *Presentation:*
		  ○ *OSHA overview of worker safety regulations*
		  ○ *OHA and ODHS regulation of behavioral health care settings*
		• *Election of chair*
			Draft Task Force rules
			Operating Procedures
			Needs assessment questionnaire

August 7th, 2024
1:00-4:00PM
	Getting Started	• Election of Vice-Chair
		• Informational Presentations:
		  ○ AFSCME background on Task Force; history of this work
		  ○ Provider perspectives
		• LPRO presents needs assessment results
		• Task Force discussion: workplan and scope
			Needs assessment results
			Draft workplan

August 30th, 2024
12:00-3:00PM
	Information Gathering	• Review status report; approve for submission
		• **Topic #1: Safety Plans and Training (new)**
		  ○ Invited speakers TBD (e.g. safety plan templates or requirements, assault reporting, trainings)
		  ○ Member discussion
			Staff memo with status report to the legislative assembly

Submit status report to the legislative assembly by September 1, 2024			

Month	Focus	Topics and Tasks	Additional Resources

September 10th, 2024
1:00-4:00PM
	Information Gathering	• **Topic #1: Safety Plans and Training (continued)**
		  ○ Review takeaways and ideas from last meeting
		  ○ Discuss priorities for draft recommendations on safety plans
		• **Topic #2: Safe Staffing Levels (new)**
		  ○ Invited speakers TBD (e.g. staffing minimums, roles, paying for staffing, contingency plans)
		  ○ Member discussion
			Summary of key takeaways/concepts from last meeting

October 3rd, 2024
1:00-4:00PM
	Information Gathering	• **Topic #2: Safe Staffing Levels (continued)**
		  ○ Review takeaways and ideas from last meeting
		  ○ Discuss priorities for draft recommendations on staffing levels
		• **Topic #3: Physical And Structural Security (new)**
		  ○ Invited speakers TBD (e.g. security and communication technology, structural elements, layout of care settings)
		  ○ Member discussion
			Summary of key takeaways/concepts from last meeting

October 16th, 2024
1:00-4:00PM
	Deliberations	• **Topic #3: Physical And Structural Security (continued)**
		  ○ Review takeaways and ideas from last meeting
		  ○ Discuss priorities for draft recommendations on physical and structural security
		• Discuss draft recommendations
			Draft recommendations

November 7th, 2024 1:00-4:00PM	Deliberations	• Members finalize recommendations • Members review report; discuss revisions if needed • **If possible: finalize and adopt report**	Draft report
November 14th, 2024 1:00-4:00PM	Adopt Report	• **Finalize and adopt report**	Final report

Month	Focus	Topics and Tasks	Additional Resources
Submit final report to the legislative assembly by December 1, 2024			

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

Meeting Date	Topics Discussed (Hyperlinks to Resources)
July 18, 2024	• 2023-2024 Interim JTFBHW Task Force Rules (adopted) • Behavioral Health Licensed Facility Overview - Connie Rush (presentation) • JTFBHW Operating Procedures • JTFBHW Needs and Opportunities Questionnaire 7.18.2024 • Overview for Behavioral Healthcare Workers Discussion - ODHS (presentation) Overview of Public Records Requirements - Erin Jansen (presentation) • Overview of Public Records Requirements - Erin Jansen (video) • Task Force on Improving Safety of Behavioral Health Workers - LPRO (presentation) • Worker Safety Regulations - Penny Wolf-McCormick (presentation)
August 7, 2024	• Aid and Assist_SB5506_SEC84_Budget Note Report (document) • Behavioral Health - Lamar Wise (presentation) • Behavioral Health Residential Facility Study June-2024 (document) • Draft Workplan JTFBHW - LPRO (document) JTFBHW Needs Assessment Results Summary - LPRO (memorandum) • OCBH Safety TF (presentation) • OHSU - Oregon Gap Analysis and Inventory Report (document) • Task Force on Improving the Safety of Behavioral Health Workers - LPRO (presentation)

November 20, 2024

Meeting Date	Topics Discussed (Hyperlinks to Resources)
August 30, 2024	• BHC Workplace Violence Prevention Standards - Mary Wei (presentation) • JTFBHW - September 2024 Status Update - DRAFT (memorandum) • JTFBHW - September 2024 Status Update - FINAL (memorandum) • JTFBHW Meeting #3 - LPRO (presentation) • JTFBHW Post Meeting Summary - Meeting 2 - Aug 7 2024 JTFBHW Supplemental materials on safety plans and training requirements 8.30.24 • OHSA Whistleblower Recommendations - Penny Wolf-McCormick (presentation) • OHSA Whistleblower Rights - Penny Wolf-McCormick (presentation) Supplemental Reading- AOCMHP Worker Safety Core Elements 2012 • Supplemental Reading- Clackamas County Field Safety Policy Supplemental Reading- OSH Policy 8.033 • Supplemental Reading- OSH Procedure - Type I • Supplemental Reading- OSH Procedure - Type II • Supplemental Reading- OSH Procedure - Type III • Supplemental Reading- OSH Procedure - Type IV • Supplemental Reading- OSH Workplace Violence Prevention Program 2023
September 10, 2024	• Behavioral Health Care Navigating Reimbursement and Staffing - Sam Byers (presentation) • JTFBHW Post Meeting Summary - Meeting 3 - Aug 30 • JTFBHW slides 9.10.24 - LPRO (presentation) • JTFBHW Supplemental materials on safety plans and training requirements 8.30.24
October 3, 2024	• JTFBHW 9-10-24 post-meeting summary (summary) • 2022 Edition Behavioral Health Design (guide) - Kimberly N. McMurray

November 20, 2024

Meeting Date	Topics Discussed (Hyperlinks to Resources)
	• JTFBHW (presentation) - LPRO Staff • Physical and Structural Security in - Home and Community Care Services Regulations (presentation) • Physical and Structural Security in Behavioral Health Setting - Facility Guidelines Institute (prese • Workers Compensation violent claims data - Department of Consumer and Business Services (memorandum)
October 18, 2024	• JTFBHW Policy Concepts for Consideration 10.11.2024 • JTFBHW Post Meeting Summary - Meeting 5 - Oct 3 • JTFBHW slides 10.18.24
November 7, 2024	• JTFBHW Draft Recommendations and Presentation JTFBHW Draft Recommendations and Presentation • JTFBHW Final Report DRAFT
November 14, 2024	• JTFBHW Final Report DRAFT • JTFBHW Presentation 11.14.24 • JTFBHW slides 11.14.24