DRAFT LEGISLATION PROPOSAL FOR MEDICAL PROVIDERS

PROBLEM (describe the problem; attach any additional information)

This is pulled from previous legislation. We can tune up the problem statement to more specifically call out the role of medical providers and data re seeing them prior to a suicide. Just sharing an older example

Suicide is the second leading cause of death in Oregon of young people ages 10 to 24, the third leading cause of death for those 35 to 44 and the eighth leading cause of death overall. Suicide cost Oregon over $740,356,000 in lifetime medical and lost work costs in 2010. According to OHA Approximately 70 percent of suicide victims had a diagnosed mental disorder, alcohol and /or substance use problems, or a depressed mood at time of death. In spite of this, there are no requirements for Oregon's physical health workforce to receive training in suicide intervention and many mental health professionals feel woefully unprepared or underprepared to deal with suicide ideation in a client. NOTE: Add data re: percentage of people who have seen health care professionals prior to attempt/suicide. Include data on attempts (2020?).

PROPOSED SOLUTION TO THE PROBLEM

Require medical providers to take continuing medical education so for any patient contact with a medical provider, they will have someone who is competent in screening and assessing for suicide; working with a patient on safety planning and reducing access to lethal means; and connect to community resources and support. This is not intended to change the scope of practice rather it is to equip the workforce to respond to an unmet need and save lives.

Require the Oregon Health Authority to:

1) Adopt and apply standards for suicide assessment, treatment and management continuing education for doctors, nurses and other medical providers in consultation with suicide prevention bodies and subject matter experts. Included professions are: a) Certified registered nurse anesthetist, as defined in ORS 678.245; b) Chiropractic physician, as defined in ORS 684.010;
c) Clinical nurse specialist, as defined in ORS 678.010; d) Naturopathic physician, as defined in ORS 685.010 e)Nurse practitioner, as defined in ORS 678.010; (f) Physician, as defined in ORS 677.010 (g)Physician assistant, as defined in ORS 677.495; (g) Physical therapist as defined in ORS 688.010, and (h) Physical therapy assistant as defined in ORS 688.010 (i) Acupuncturist
2) Require suicide assessment, treatment and management continuing education for licensed physical health care providers. The training must be approved by the relevant licensing/credentialing authority and must include the following elements: suicide assessment, including screening and referral, suicide treatment, and suicide management. A licensing/credentialing authority may approve a training program that does not include all of the elements if the element is inappropriate for the profession in question based on the profession's scope of practice. A training program that includes only screening and referral must be at least three hours in length. All other training programs must be at least six hours in length. A licensing/credentialing authority may specify minimum training and experience necessary to exempt a practitioner from the training requirement.

Commented [1]: add a section on exemptions? specific professions? people within the professions that don't have client care?

Commented [2]: Do we also have any data health care professionals' feelings of (un)preparedness to work with a suicidal patient?

Commented [3]: pull from WA legislation around the hours required for different professions

Commented [4]: differentiate between who and who doesn't treat

Commented [5]: Differentiate between workforces and required number of hours they need. Example: doctors need 6 hours but chiropractors need 3.

Commented [6]: Boards to determine who needs what level of training but OHA determines what is in the training? Boards can help with exceptions and levels of expertise.

Commented [7]: How are we defining suicide treatment? It's not always the role of the health professional to treat as they often refer out. This may need a more nuanced definition (unless that's something that comes with rules?).

Commented [8]: I'll look at the HB 2315 rules and / or other OARS and see if these terms are defined

Commented [9]: Same as above - what do we consider suicide management?

Commented [10]: if your board determines you only screen, you need this level of training. if your board determines...

Commented [11]: Are we allowing multiple trainings to equal six hours or does it have to be one training? And is this annually?

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3) Develop a model list of training programs in suicide assessment, treatment, and management that meet minimum standards.

If existing courses do not meet minimum standards, OHA develops Oregon specific 6-hour training (including the infrastructure below) (Add description of minimum standards for training, including content that meets culturally specific needs). The training required must be at least six hours in length, unless a disciplining authority has determined that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length. Consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management to contract for training development should OHA not have the capacity to develop training.

4) By January 2024, the department shall adopt rules establishing minimum standards for the training programs included on the model list. The minimum standards must require that six-hour trainings include content specific to higher risk populations and the assessment of issues related to imminent harm via lethal means or self-injurious behaviors .

5) Beginning July 1, 2025, the model list must include advanced training and training in treatment modalities shown to be effective in working with people who are suicidal. The list will be updated at least every two years.

6) Develop centralized website with a training registry of existing and approved suicide assessment, treatment and management continuing education options

7) Provide funding to support licensing board implementation of suicide assessment, treatment and management continuing education for licensing and re-licensure

8) Establish infrastructure to support and monitor licensee engagement in suicide assessment, treatment and management education.

Commented [12]: Define what we mean by model / minimum standards. #2 says they will establish this.

Commented [13]: Would we also need shorter trainings for different professions that wouldn't be required to take 6hours like chiro?

Commented [14]: Two different training tracks: one of screening and referral; one of screening, referral / treatment

screening and and assessments are different

Risk or safety assessment. Use same definitions from HB2315 process

Commented [15]: Example: WA has one for veterans

Commented [16]: and any other standards the Authority determines to be a minimum standard" or something like that

stabilization, de-escalation, etc.

Add language while also recognizing that the RAC will dive into this more deeply and specifically.
Scope of practice

Commented [17]: does this need to specify evidence based trainings?

Commented [18]: should we be more specific around funding ask? such as an amount, length of time, etc. do we need to include this in the legislation?

Commented [19]: what was done for the pain management requirement - was there funding for boards to implement this?

Commented [20]: who will establish this? OHA? is this similar to SB 48 process with reporting requirements?