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FPS Project Review Rule Advisory Committee
May 22, 2024
1:00 PM – 4:00 PM via Zoom

RAC MEMBER ATTENDEES	
Aaron McGarry	GMA Architects
Barbara Hansen	Oregon Palliative Care & Hospice Association
Barbara Tauscher	Pacific Medical Practice Consultants, Inc.
Ben Taylor	Clark/Kjos Architects, LLC
Chris King	Fresenius Medical Care
Chris Skagen	Oregon Ambulatory Surgery Center
Cindy Wagner	Salem Health
Danielle Meyer	Hospital Association of Oregon
Elaine La Rochelle	Grande Ronde Hospital
Janice Sanada	LRS Architects
Jeff Taylor	Providence Health & Services
Jeremy Stremme	Legacy Health
Jon Anderson	Anderson Dabrowski Architects
Jon Mehlschau	SRG Partnership Inc
Justin DeGan	Adventist Health
Kelly Chanopas	ZGF Architects
Kristin Videto	Davita
Marcy Pierce	Asante
Matt Ottinger	JRJ Architects
Matt Stormont	PeaceHealth
Naomi Mathaba	OHSU
Sarah Kershner	PKA Architects
Tim Clem	Oregon Society for Healthcare Engineering

Oregon Health Authority (OHA)/Oregon Department of Human Services (ODHS) Staff	
Jerimiah Adams	ODHS – Nursing Facility Licensing
Meghan McLain	ODHS – Community Based Care
Vickie Surico	ODHS – Community Based Care
Warren Bird	ODHS – Community Based Care
Barbara Atkins	Oregon Health Authority (OHA)-Public Health Division (PHD)-Health Care Regulation and Quality Improvement - Facility Planning and Safety Program
Lisa Humphries	OHA-PHD-Health Care Regulation and Quality Improvement - Facility Planning and Safety Program

Matt Gilman	OHA-PHD- Health Care Regulation and Quality Improvement - Facility Planning and Safety Program
Mellony Bernal	OHA-PHD-Health Care Regulation & Quality Improvement
Patrick Young	OHA-PHD- Health Care Regulation and Quality Improvement - Facility Planning and Safety Program
Shane Jenkins	OHA-PHD- Health Care Regulation and Quality Improvement - Facility Planning and Safety Program

Welcome, Housekeeping and Agenda Review

Mellony Bernal introduced herself and welcomed attendees to this rule advisory committee, the purpose of which is to consider changes to Oregon Administrative Rules chapter 333, divisions 675, 071, 076 and 535, which will include changes to the project plans and construction review process; amending FGI standards for Ambulatory Surgery Centers (ASCs), Extended Stay Centers (ESCs), Hospitals and Special Inpatient Care Facilities (SICFs); and making some minor housekeeping changes due to passage of legislation.

Housekeeping items for RAC participation reviewed:

- Attendees were asked to enter their name, title and organization into the Chat. Participants not considered a RAC member were asked to identify themselves in the Chat as a public participant.
- Attendees were asked to keep devices muted until called upon.
- RAC members were asked to type the word "Comment" to indicate they wanted to speak to a particular issue or ask questions. Persons were called upon in the order they appeared on the Chat.
- RAC members who did not want to talk but who wanted to share information were asked to type into the Chat "For the Record" and include the information they wished to share.
- It was noted that pursuant to the OHA policy, members of the public may attend but may not participate or offer public comment during the meeting. Members of the public who wished to provide comments or information were asked to email those comments to mellony.c.bernal@oha.oregon.gov or barbara.s.atkins@oha.oregon.gov at the conclusion of the meeting.
- It was further noted that after the RAC meeting process concluded, there would be an opportunity to provide oral public comments at a public hearing, or to send written public comments during the public comment period. Information about the notice of proposed rulemaking and public hearing will be shared.
- It was noted that the RAC meeting would be recorded, and the recording and information shared in the Chat is public record and therefore subject to disclosure.
- Meeting notes will be drafted and shared with the RAC and posted on HCRQI's rulemaking activity webpage: http://www.healthoregon.org/hcrqirules.

Roll call of the RAC members was taken and RAC members introduced themselves. Staff members from both Oregon Health Authority and Oregon Department of

Human Services also introduced themselves. RAC members were asked to share what they hoped to gain from rulemaking process and following comments were shared:

- Incremental improvement to processes to address issues that are burdensome.
- Ensure that regulatory requirements don't create barriers for hospice programs to be able to implement.
- Ensure representation of ASC owners and consider applicability to ASCs.
- Help to further incorporate incremental feedback and increase dialogue with OHA.
- Seek clarity and transparency around interactions with OHA.
- Continue to develop and improve relationships with FPS staff.
- Ensure representation of long-term care and seek clarity and consistency.
- Transparency and clarity around waiver process.
- Opportunity to clean up language and make the code better than before.
- Improve collaboration and efficiencies with plans review process.
- Ensure representation of the ESRD population.
- Improve value of relationship with FPS to make sure meeting all of the requirements in health care plus serving communities.
- Clarity around when a project must be submitted for FPS review.
- Help make amendments and changes that allow clients to provide better care.
- Collaboratively work on establishing regulations and submission processes that provide for patient and staff safety and balance against the financial impact to the provider resulting from construction costs and time.

Matt Gilman noted for awareness that the FGI standards were only adopted for acute care and not long-term care facilities.

The agenda was reviewed, and it was noted that the next meeting is scheduled for June 3 at 9:00 a.m.

Rulemaking Advisory Committee Overview and Scope

M. Bernal provided an overview of the RAC process, scope and timeline:

RAC Overview:

- State agencies convene RACs for a variety of reasons including when the legislature passes laws that require rules be adopted, when the agency needs to clarify process or intent, and sometimes as a result of community partner feedback.
- RAC members include persons and communities that are most likely affected by the proposed rules including representation from licensed facilities, special interest groups, and associations.
- RAC members will consider the proposed text drafted by HCRQI and raise any concerns or issues or offer other suggested language. Additionally, the RAC will

review the Statement of Need and Fiscal Impact (SNFI) which also includes a statement on how the proposed rules may affect racial equity in Oregon.
- Considering information provided by the RAC, HCRQI will finalize proposed rule text and submit notice of proposed rulemaking to the Secretary of State along with the SNFI.
- A public hearing will be scheduled where persons can present oral testimony or submit written comments. The public hearing's officer that presides over the public hearing will generate a report summarizing the comments.
- HCRQI will review and consider all testimony and comments received and determine whether additional changes to the rule are necessary based on those comments.
- HCRQI will provide a response to the hearing's officer report.
- HCRQI will finalize rule text and determine effective date and file permanent rulemaking notice with the Secretary of State's office.

Rule Number:

The parts of a rule number were shared for awareness.

RAC Scope

The purpose of this RAC is to consider addressing the following:

- Adopting new rules for clarity. It was noted that several different topics were listed under OAR 333-675-0000 and FPS is proposing to break those topics into new rule numbers.
- Updating the cost threshold for review requirements;
- Clarifying the functional program requirements;
- Clarifying major project change provisions;
- Amending the schematic design and construction document review process;
- Amending FGI standards for ASCs, ESCs, hospitals and SICFs;

- Amending rule text to align with statutory changes;
- Seeking input and suggestions on development of new and amended rules;
- Seeking input on the potential fiscal and economic impact of proposed changes on affected parties; and
- Consider what effect, if any, proposed rules may have on racial equity in Oregon.

Timeline for Rule Submissions

- The following estimated timeline was shared with RAC members and is dependent on how quickly the RAC will be able to get through proposed changes:
- FPS plans to hold two to three meetings between May and July;
- Submit final proposed rule language to the PHD Rule Coordinator by August 16, 2024;
- Post Notice of Proposed Rulemaking in the September 1, 2024 Oregon Bulletin;
- Hold a public hearing on or after September 15, 2024;
- Close written public comment deadline on or after September 21, 2024;

- Review comments and respond to hearing's officer report;
- File final permanent rules on or after October 15, 2024; and
- Have rules go into effect January 1, 2025.
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Administrative Rule Review

Housekeeping – OAR chapter 333, division 71

- M. Bernal summarized housekeeping changes that are being made to OAR chapter 333, division 71 (SICF rules) due to passage of legislation. It was noted that these changes are being made to align with revised statutes and the need to discuss should be limited.
  - HB 4010 (2024) – The term 'physician assistant' will be updated to 'physician associate.'
  - SB 556 (2023) – A reference to the term "in-person" inspection replaces the term "on-site." This change will not affect the built environment inspections.
  - HB 3036 (2021) – Language regarding granting or refusing privileges was updated.
  - A spelling error has been made to correct the reference from an "ASC" to an "SICF."

M. Gilman provided an overview of the document that identifies where proposed changes are tracked in one column and where staff will document feedback from the RAC in the adjacent column. The meeting recording will be used to double-check accuracy and amend captured comments as needed.

Barbara Atkins shared that staff are considering modifying the descriptions of facilities within the rules for accuracy. For example, the rule title references residential care facilities and assisted living facilities but does not reference nursing homes or skilled nursing facilities. The program must verify statutory authority and will further coordinate with the Department of Justice.

B. Atkins noted that program has renumbered rules for clarity.

OAR 333-675-0100 – Applicability

A new rule has been added clarifying the purpose of these rules which is a standard practice. In addition, specific references to programs or sections have been removed and replaced with the more general term 'Oregon Health Authority.'
Discussion:

- RAC members in the Chat indicated 'no comment' or 'no concerns about applicability or renumbering.'

OAR 333-675-0105 - Definitions

This new rule identifies terms and definitions. The FPS program received a comment asking to clarify the application of FGI 1.1-3 Renovations; specifically, the extent of applying FGI standards to adjacent or related areas and infrastructure that are outside the intended scope of the project. Discussion:

- RAC member indicated that a member of OSHE shared this feedback. Example was provided – Replacing a 'GE' Xray with a 'Phillips' Xray; how far does FPS scope reach? Does it include housekeeping closet, HVAC ducts, etc.? There is no clear definition or description of what the scope will be in FGI.
- RAC member via Chat agreed and indicated a more objective way of establishing scope of work of a remodel project would be appreciated.
- B. Atkins shared example of a fluoroscopy Xray where FGI states that a toilet room is necessary to service the fluoroscopy imaging room.
    - Since standard reflects that a toilet room is necessary, FPS staff have reason to inquire about the toilet room.
    - FGI 1.1-3 – review shall commence for the "areas affected" by the project.
    - **Follow-up:**
      1.1-3.2.1 – Affected areas - In renovation projects and additions to existing facilities, only that portion of the total facility affected by the project shall be required to comply with applicable sections of the Guidelines.
      1.1-3.2.2 – Unaffected areas - Existing portions of the facility and associated building systems that are not included in a renovation project but are essential to the functionality or code compliance of the renovated spaces shall, at minimum, comply with the applicable occupancy chapter of NFPA 101: Life Safety Code®.
    - **ASHRAE 170 (found in Part 3 of FGI) includes 2.2 "This standard applies to new buildings, additions to existing buildings, and those alterations to existing buildings that are identified within this standard."**
    - **ASHRAE 170 (found in Part 3 of FGI) includes 4.1.2.2.2 "Space Alterations. Alterations. to spaces listed in Tables 7- 1, 8- 1, 8-2, and 9-1 shall comply with the requirements of Sections 6.7, 7, 8, and 9, applicable to those specific portions of the building and its systems that are being altered."**
    - ASHRAE 170 – Mechanical, ventilation compliance requirement has language about items impacted or affected by the project. Feedback from mechanical engineers would be appropriate.
    - In addition to design, need to consider mechanical implications, fire life safety implications, etc.
    - RAC member stated that for hospital systems in imaging areas and areas using anesthesia gases, there is a big impact to the room requirements creating a need to be very specific in rule and not require changes that are not applicable to a project.

- RAC member shared there are projects that will require their own housekeeping closet. If working on a project, and housekeeping closet is mentioned, is it required to also ensure that the housekeeping closet, for example, is more than 35 sq ft?
    - B. Atkins responded with an example of a newborn nursery that requires a housekeeping closet and noted that staff will make sure that there is a closet. If you have it, and its existing license and not connected to or touching the nursery, it may not be reviewed. But if there is no closet and one needs to be made, it would need to meet all of the requirements.
    - RAC member agreed that if it under an existing license, stop; if you don't have, it must meet requirements. There is nothing in the FGI that states just because it is referenced that it must be made to comply with FGI. RAC member agreed via Chat with this statement.
- RAC member requested more clarity on FGI 1.1-3. Many hospitals have been licensed for decades under previous iterations of OARs. If licensed previously, and the project is only to replace equipment, the scope of work should only be confined within that room. Where are the limits, under section 1.1-3, of areas affected by this project (e.g., are all exits properly sized?) Language is too vague and allows licensing to add additional requirements outside scope. Some facilities are operating on limited funds and do not have the resources necessary to make additional changes that go beyond the scope.
- Several RAC members agreed via Chat on clarifying scope.
- RAC member asked what the bright line for grandfathering of existing buildings was, as opposed to improvements.
- FPS staff member noted that equipment replacements for the most part, affects only the room, but as equipment becomes more powerful it makes more heat, and sometimes need to pull water several floors away, which requires additional review. When infrastructure demands increase, then additional review may be necessary, but agreed that staff must be careful to not go outside the lines under existing license.
- B. Atkins noted in Chat, text from 2018 FGI, general outpatient clinics: "2.2-1.1.3 Requirements in Chapter 2.1, Common Elements for Outpatient Facilities, shall apply to general or specialty medical services facilities <u>when cross-referenced</u> in this chapter. Example – general outpatient clinic language, cross references another section – go to that section and review but do not go to other locations not included in the scope of license. B. Atkins asked if that language might be useful?
- RAC member asked via Chat whether adding language that would separate function from meeting current section requirements for existing license spaces would help, noting that if the housekeeping closet exists and one is required, then the requirement is met.

- Via Chat and follow-up discussion, RAC member noted that equipment replacement is a big issue. It was noted, "Can we break out medical equipment similar to floor, paint, casework? There will be MEP anyway if the new equipment needs additional MEP support."
- M. Gilman indicated that FPS staff will consider whether interpretive guidance could be generated versus adding specific text to rule. Adding to rule may have unintended consequences and would be difficult to change quickly; whereas interpretive guidance can be reviewed regularly and updated as needed. Follow-up comments in the Chat:
    - Interpretive guidance would be helpful to support clarity.
    - Pre-review consult to get clarity going into construction would be a great resource.
    - It's difficult to contemplate every instance that will arise when writing rules and interpretive guidance is a way to help as trends are noted.
    - Support clarity and would appreciate the option to propose language for approval.
    - It would be helpful if something is accessible prior to SD/CD review, so expectations can remain monitored and accounted for in budgets.
    - OAR 333-675 could use defined triggers for FPS review for work that exceeds general maintenance or equipment replacement as a project type. Could there be an exception for informing FPS of the work without triggering the CD review process?
- RAC members were encouraged to consider possible language and send proposed text to B. Atkins, M. Bernal, and M. Gilman.

B. Atkins opened discussion specific to the proposed terms and definitions. The document shared includes the source of where the definition came from. RAC members were asked if there were any concerns with any of the definitions excluding definitions #7, 8 and 10.

- RAC member noted concern with the term 'occupancy type' under the definition of "conversion projects." This is about a change of use and not occupancy. Occupancy is relevant to building codes not licensure rules. RAC member noted that it is not common that we are changing occupancy (it's all I-2 occupancy inside a hospital) rather change of use which is important under FGI. (FPS staff noted that FGI used the term 'occupancy type')
- It was noted that the terms "change of use" and "conversion projects" seem interchangeable. FPS staff commented that there are specific example to prove otherwise. Example of a freestanding birthing center was shared as a conversion project, where a home is purchased and is made into a birthing center.
    - PR1 form notes that when converting a space from unlicensed to licensed, it is referred to as a conversion. The fee is based on the taxed assessed value of the property.

- Example shared of long-term care facilities that have a conversion project when a skilled nursing facility is converted into a residential care facility (reference OAR 411-054-0200 and OAR 411-054-0005 (23).
- OAR 333-675 also refers to a project must be submitted for review when there is significant change in the use of the room or space, which introduces term of "significant change in the use."
- Via Chat, RAC members noted:
  - NFPA 101 3.3.45 Change of Use. A change in the purpose or level of activity within a structure that involves a change in application of the requirements of the Code.
  - NFPA 101 3.3.44 Change of Occupancy Classification. The change in the occupancy classification of a structure or portion of a structure.
  - Eliminate "significant" and list "change of use," unless significant is defined.
  - Clarification on threshold is needed.
- RAC members agreed that further wordsmithing is needed.

Discussion regarding definitions "major renovation project," "minor alteration," and "renovation" followed:

- RAC member asked – where does moving a door from one end of the wall to the other fall - major or minor alteration? B. Atkins noted that further information on the project would be needed to assess.
- The following comments were made by RAC members via Chat:
  - A clear definition of major/minor *alteration* would be helpful. Several RAC members concurred.
  - A clear definition of major/minor *renovation* could be beneficial.
  - A clear threshold is needed.
- RAC member commented that current FGI and ASHRAE 170 can be used to verify that a change of use complies with standards. Functional program explains intent and why changes are being made but there are other things like case work and finishes that does not make it a 'major project.'
- RAC member asked for clarification on the term "physical plant" within the definition of 'major renovation.' Applicability to ASCs was questioned based on size of ASC that may only have simple HVAC systems.
  - RAC member agreed that more clarity is needed – is it HVAC, emergency power, water, electrical? Need to be more specific, e.g., CUP project (central utility plant)? ASCs do not have a central utility plan but do have an electrical room, air handling unit, emergency generator, medical gas, compressors. Are they part of the 'physical plant'?
  - FGI hospital 2.1-5.6 (Engineering and Maintenance Service) – perhaps rather than physical plant, the reference should be to 'building systems' or updates to the building systems, engineering and maintenance services within an existing building.

    - RAC member commented if referring to systems and a major renovation is defined as 'a series of planned changes and updates to the system,' is further clarification needed? Will it apply to a boiler change out, TU boxes? Where does it stop? It was noted that the value threshold will come into play.
- B. Atkins noted that based on discussion a clear definition for major and minor renovation is needed which will help support interpretive guidance and program policies about how the FPS team reviews these projects and the spaces impacted by them. RAC members concurred.
- RAC member asked when do minor efforts rise above the level of repair and referenced definition of "repair" such as replacement of equipment, swap out of boiler – technically may be upgrades but is really maintenance. Does FPS review repairs? The threshold of 25% of equivalent replacement cost under OAR 333-675-0000(2)(b) was noted.
    - RAC member stated that clarification on the building infrastructure is needed. There really isn't a way to define what the equivalent replacement cost is on an entire mechanical system. Would like to see this section broken out more.
    - RAC member noted that MEP infrastructure that services both patient care area and non-patient care areas should be reviewed by OHA despite costs. Major and minor needs to be clear and consider whether it is connected to inpatient care versus outpatient.
    - RAC member indicated the cost threshold appears arbitrary and defining connection to patient care is a good avenue. Any dollar threshold should be re-reviewed on an annual basis to ensure alignment with cost of inflation and escalation of costs.
    - It was noted that how major and minor are defined will impact language around cost thresholds.

B. Atkins opened discussion regarding "technically infeasible" definition, loosely sourced from NFPA 101 (i.e., cannot move a structural column to increase the size of an exam room). Do we make it clear the difference between technically infeasible and cost prohibitive?

- RAC member shared examples of structural changes that absolutely cannot be moved (e.g., columns, elevator shafts or mechanical shafts). Feasible infers if it can be done, it is possible. But this may require more construction to accommodate a space. It should be done if a space cannot be safely used otherwise, and it should then meet FGI.
- Staff raised example of and discussed remodeling existing licensed emergency department rooms and possible affect on room size, reduction of services, and safety. An example was provided describing an existing licensed emergency department (ED) wanting to remodel, but existing licensed treatment rooms are too small. It is technically feasible to increase size of rooms but would reduce the quantity of rooms when fewer rooms may reduce services. Staff also noted that FPS sometimes reviews existing or proposed ED rooms that are so tiny they

simply don’t work. A remodel of an ED needs to meet requirements. If you have done all this work to increase the (emergency) department size, it is not reasonable to propose or leave inadequate rooms when all this work has occurred around those spaces. Technically infeasible is more about structural bays versus cost.

- Staff noted that patient bed floors are often based on smaller room sizes for same acuity, and toilet room may not meet new requirements, headwalls not long enough, and so patient bed floors get beat-up and worn out. However, not so worn out that a facility is interested in a blow-out of the floor, and not designed with a structural bay that allows for that size of room. Waivers are often implemented to accommodate.
- RAC member noted that as an architect during the design process, drawings won't be submitted with compromises already identified and requesting waivers. Meeting FGI compliance resulting in a loss of rooms is an operational impact on the owner since rooms are revenue generating. Square footage doesn't matter as much as loss of rooms. This is part of the pre-planning process and understanding the requirements and having a dialogue with OHA. It's a process that needs to be added early-on.
- Via Chat, RAC members shared:
    - Alternative ways to be compliant would be a nice way to help serve patients with building or price constraints.
    - There would also be the impact to patient care that would be required to shut down and modify all those rooms to move a wall over 1', as an example. That's related to not just the cost of the work or eventual loss of patient rooms, but also to patient experience and patient safety during construction, especially in locations like an ED where it cannot be closed for overnight construction.
    - Experience of moving a wall a very small amount to be compliant and indicated understanding that they can't have too much leeway.
    - Agree with pre-planning dialogue.
    - Should be able to do this well before SD in a pre-conference.
    - Agree with compromising existing operations.

M. Gilman asked whether there is something more specific about addressing patient and staff safety that should be included.

- RAC member indicated rural hospitals need to be considered and noted concern about safety of staff when, for example, overhead lifts being added to old hospital patient rooms. There is an inherent conflict when trying to increase patient safety and putting lifts in rooms that are not adequately sized per FGI.
- RAC member concurred that rural hospitals are operating on very tight budgets to serve populations. "Let's not let great be the enemy of good."

OAR 333-675-0110 – Project Plan Submission and Review

B. Atkins opened discussion about amendments trying to clarify the types of facilities subject to review. Rule has been modified to have more general references to the Authority versus specific program names and information.

- RAC member asked why the reference to 'specifications' was removed from title of rule. It was noted that 'specifications' isn't removed from rule text rather it's just simplifying the title of the rule. It was recommended to change the title to Project Submission Review.

Section (2) relating to when a project must be submitted for review was discussed, specifically changes to the cost threshold. The cost threshold value has not been changed since 1994. It was noted that Andersen Construction provided a cost construction index graph which identifies construction cost increases from 1994 to 2024 compared to the consumer price index (CPI).

- Question via Chat was raised whether the cost increases shown are for Oregon or nationally. It was noted that there are both national costs listed as well as for Portland and Seattle.
- Graph represents cost index increases from the following construction companies and a construction industry magazine company.
    - RLB - National and Portland
    - Mortenson - National and Portland
    - Turner
    - ENR – National and Portland
- Question was asked via Chat whether rules could be written in a way that costs could be adjusted without a rule change. M. Bernal noted the OHA could check in with Department of Justice, but standard practice is that specific details on costs or dates must be identified in the rule. Additional questions were posed and shared via Chat about more consistent reviews perhaps annually.
- RAC member suggested via Chat that the hospital market basket could be a good inflation adjustment indicator.
- RAC member stated that a regular review of the cost threshold is necessary both for the industry and the OHA to ensure there are enough resources to support the work including through increased fees. It was noted via Chat that if an annual review is not feasible, then at a minimum it should be reviewed at every FGI adoption update.
    - RAC member indicated there are not enough OHA staff to support the influx of work which is hurting the hospital systems and therefore patients.
    - RAC member noted that the last fee increase was 2015 [*FPS staff wish to note for record that last review fee increase was January 01, 2018*] and that since the FPS program is fee supported, it should look at a fee increase in order to obtain more staff and faster turnaround times. Several RAC members stated and posted via Chat concurrence and support of a fee increase. M. Gilman noted that increasing fees is very difficult and all fee increases must be approved by the Oregon Legislature through agency budget reviews.

    - It was noted that raising the cost threshold will reduce the number of projects that must be reviewed by the OHA and therefore increasing overall time to work on other projects. RAC member stated that while a threshold increase may reduce the number of projects, it is still so low that it will likely not make a huge difference in workload. Other solutions should be considered.
    - RAC member stated compared to the overall cost of a job, the fee is small in comparison.
    - RAC member questioned whether in rule an established increase can occur over time for both the threshold and fees. RAC member indicated via Chat agreement with a graduated threshold, and potentially to start with raising the threshold to $150,000 versus the $100,000 currently proposed.
    - RAC member indicated via Chat that increased fees can be a barrier to smaller, private practice groups undertaking a building or expansion project. B. Atkins also acknowledged the impact to smaller businesses such as some of the long-term care facilities.
    - RAC member via Chat asked, "Will the cost threshold be assessed by the hard costs only? Or is equipment included in the threshold? That can swing widely with imaging projects."
- RAC member asked via Chat how the initial threshold of $50,000 was decided. Staff noted that no documentation has been found that has identified source.
- RAC member stated that projects between $50,000 - $150,000 are generally 'enabling' projects and has a time component for the hospital. Increase in threshold will ultimately help patient populations.
- Based on previous discussion about major and minor renovations, M. Gilman asked if "cost" is the best way to determine what should be reviewed? M. Gilman asked RAC members to consider what criteria is used to determine a major project when working with decisions makers on a proposed project.
    - RAC member noted that the threshold amount is arbitrary – if the intent is to limit projects that don't necessarily need OHA review, does that control what is chosen for the threshold amount? Example shared of Xray replacement project where conduit alone is $150,000. This isn't a major project and OHA shouldn't review but it is over threshold amount.
    - RAC member concurred and noted that any MEP project is going to be over $150,000 versus a small clinic review. A different way to consider projects should be thought about – major versus minor; component of a project is costly but doesn't warrant review; HVAC; etc.
    - RAC member via Chat indicated agreement about clarifying whether equipment costs are included in the amount used to decide whether to submit.
    - RAC member commented that we need to try and get subjectivity out of consideration. Cost is not sole way, but how can efficiency and speed be increased based on number of projects that need to be reviewed.

- RAC member via Chat suggested risk management versus cost – the patient is the concern and maybe not the cost. Consider risk categories to determine plan review requirements.
- RAC member via Chat indicated that in terms of determining major or minor, the facility looks at extent of demo needed to meet intent of the project, and amount of infrastructure being touched.
- RAC member suggested if a project is right on the line of threshold, perhaps project team and provide a brief with criteria clarifying why it's minor and not major.
- B. Atkins noted that some states have a self-attestation process. The team considered but the agency may not have statutory authority to pursue. Perhaps this is something that can be considered in future. M. Gilman noted that OHA is looking at other states who have adopted FGI to consider best practices that can be adopted.

- B. Atkins asked RAC about thoughts in terms of what to raise the threshold to.
  - RAC member via Chat indicated "$50K is now $150K which could be escalated 5% annually to avoid revisiting annually."
  - Via Chat, RAC member suggested $125K and $250K
  - RAC member indicated the data is available to justify the $156,000 and split for long-term care.
  - A longer-term conversation is needed on the subjectivity (fee or risk).
  - Minimum should be $75,000 and $150,000, assuming fees are revisited on a regular basis.
  - RAC member asked if threshold is for direct construction costs only? B. Atkins responded with information found on the PR1 form: "Project Costs" are all costs directly associated with the project, including but not limited to the following: building costs, all fixed or installed equipment in the project, and contractor supervision, inspection, and overhead costs. "Project Costs" exclude the following costs technologically advanced clinical equipment costs including but not limited to: X-Ray, CT, Linear Accelerator, or MRI; architectural or engineering fees; land acquisition costs; offsite improvements; and local authority having jurisdiction improvement programs.
  - RAC member via Chat indicated that if the amount includes more than direct construction, an increase above $150,000 could be justified.
  - RAC member via Chat indicated more definition on technical equipment is needed. Dialysis RO systems can be over $350,000. Clarification is needed on if those fall under 'technologically advanced clinical equipment.'
- M. Gilman, with agreement from RAC, proposed to table discussion. Staff will check with other fee-based programs to determine how we might consider adding inflation into rule.

Subsection (2)(c), reference to dietary or laundry service is very limited, and it was suggested this be replaced with clinical support services. No comments from RAC members.

Subsection (2)(d), updated language removing reference to "correction of licensure" and "code deficiency" with built environment citation. Agency names also updated.

- RAC member indicated that when a citation from surveyor is received, it must be addressed within 45 days. Concern was raised about the length of time it takes to respond to citation and follow-up actions from OHA. M. Gilman clarified that it's only a plan of correction that's needed. B. Atkins further clarified fire-life-safety (FLS) citations at nursing homes and recommendations that the Plan of Correction include a statement that a plan will be submitted to OHA within 45 days and a PR number issued. The burden is then placed on OHA to review it in a timely manner.

Subsection (2)(f) was added indicating that when permits are required by the local authority having jurisdiction, then projects must be submitted for review.

- RAC member indicated that this would circumvent any of the lower threshold projects, because almost every project will require MEP permits. Not all of them require structural permit. This will increase the load that will be required to reviewed by OHA. If goal is to review only what is necessary, then this will defeat that purpose.
- RAC member via Chat asked is 'permits' only limited to building permits, or does it also include over the counter trade permits? Could this be defined more clearly?
- RAC member via Chat indicated that this would be everything we do, hundreds of projects.
- RAC member indicated via Chat that it should be removed, and it should be covered by other criteria.
- Multiple RAC members via Chat concurred with removing.

OAR 333-675-0120 – Functional Program Requirements

B. Atkins noted that the intent of all of the changes to text is to correctly identify the functional program requirements based on facility type.

- RAC member asked about how FGI is referenced in the rule. Staff responded that the 2018 version of FGI is adopted by reference within the facility rules such as 333-535 for hospitals, 333-076 for ASCs, etc.
- RAC member expressed concern about the difference between the functional narrative submitted pursuant to OAR 333-675 versus the requirement under FGI. It was asked whether the OAR format could be used versus FGI. Staff noted that when projects are received, staff do not go to FGI to line-item check; however, it was noted that the format is nice when received. The functional narrative is not a product of the architect rather the facility. RAC member responded that the functional narratives have become longer and are

more difficult to put together versus the OAR version. Due to origins of FGI there is more architectural input than facility.

Discussion ended.

Next Meeting
The RAC will begin review at OAR 333-675-0130 on June 3rd at 9:00 a.m. It was noted that based on pace of review, it is doubtful that review will be completed within two meetings. M. Gilman noted that rather than going fast, it's important to take the time to do it right. M. Bernal will be sending out information on the June 3rd meeting including agenda and meeting link. M. Gilman thanked RAC members for their participation and engagement in the process.

Meeting adjourned at 3:58 p.m.