FPS Project Review Rule Advisory Committee
August 28, 2024
9:00 AM – Noon via Zoom

RAC MEMBER ATTENDEES	
Aaron McGarry	GMA Architects
Barbara Hansen	Oregon Palliative Care & Hospice Association
Chris King	Fresenius Medical Care
Danielle Meyer	Hospital Association of Oregon
Elaine La Rochelle	Grande Ronde Hospital
Jeff Taylor	Providence Health & Services
Jeremy Stremme	Legacy Health
Jon Anderson	AD Architects
Jon Mehlschau	SRG+CannonDesign
Justin DeGan	Adventist Health
Kelly Chanopas	ZGF Architects
Kristin Videto	Davita
Marcy Pierce	Asante
Matt Ottinger	JRJ Architects
Matt Stormont	PeaceHealth
Naomi Mathaba	OHSU
Nedzib Biberic	PAE Consulting Engineers
Sarah Kershner	PKA Architects

Oregon Health Authority (OHA)/Department of Human Services (ODHS)	
Jerimiah Adams	ODHS – Nursing Facility Licensing
Barbara Atkins	OHA-PHD-Facility Planning and Safety Program
Lisa Humphries	OHA-PHD-Facility Planning and Safety Program
Matt Gilman	OHA-PHD-Facility Planning and Safety Program
Mellony Bernal	OHA-PHD-Health Care Regulation & Quality Improvement
Patrick Young	OHA-PHD-Facility Planning and Safety Program
Shane Jenkins	OHA-PHD-Facility Planning and Safety Program

Welcome and Housekeeping

Mellony Bernal introduced self and welcomed attendees to this fourth rule advisory committee meeting where RAC members will continue reviewing changes to OAR 333-535 and recommended changes to hospital FGI requirements and outpatient FGI requirements.

- A brief overview of the previous meeting topics was shared:
  - May 22, 2024 and June 3, 2024 RAC meetings focused on changes to the project review process under OAR 333-675.
  - July 17, 2024 meeting focused on amendments to the FGI standards for Special Inpatient Care Facilities, Ambulatory Surgery Centers, Extended Stay Centers and began to review the standards for hospitals.
- Given consideration of time, rather than roll call and introductions, 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.
- It was noted that since the Oregon Department of Human Services (ODHS) has not adopted the FGI standards, any representatives from ODHS attending the meeting could choose to drop off of the call.
- RAC members were asked to type the word "Comment" to indicate they wanted to speak to a particular issue or ask questions or may also use the raise hand feature. 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 the RAC meeting would be recorded, and that the recording and information shared in the Chat is public record and therefore subject to disclosure.
- Pursuant to the OHA policy, members of the public may attend but may not participate or offer public comment during the meeting.
- Staff will be trying to enter live feedback during the meeting, but it was noted that the meeting recording will be reviewed and used to edit this information afterwards and for purposes of drafting meeting minutes.
- RAC meeting agendas and meeting notes are available on the FPS rulemaking activity webpage at: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHCAREPROVIDERSFACILITIES/FACILITIESPLANNINGSAFETY/Pages/FPS-Rulemaking-Activity.aspx.
- A public hearing will be scheduled after the RAC process has ended where persons can provide oral public comments as well as a written public comment . Dates for the public hearing and written public comment period will be sent out by email and posted on the rulemaking activity web page.
- Lastly, a meeting poll link was sent out via email on 8/27/2024, and RAC members were provided the link in the Chat and reminded to register which September dates worked for them.

Administrative Rule Review

OAR 333-535 – New Construction and Alterations of Existing Hospitals

Barbara Atkins opened discussion noting that these are proposed amendments to the 2018 FGI Guidelines which have been adopted by the Oregon Health Authority (OHA) for acute care facilities and do not apply to long-term care facilities (RCFs, ALFs, or SNFs) or birthing centers. Some of the proposed amendments are based on the revised 2022 FGI standards and the proposed 2026 FGI standards that are currently out for comment. It was noted that neither the 2022 nor 2026 FGI Guidelines are being adopted in entirety for purposes of these rules.

OAR 333-535-0015 – Physical Environment

Section (5) – Amendments to FGI standards for hospitals:

2.2-3.4.1.2 – Imaging Services - Imaging Room Classification
OSHE has requested OHA add language that the facility shall determine Imaging Room classification which must be documented in the functional program. B. Atkins noted recent projects where deep sedation may be performed in either Class 1 or Class 2 imaging rooms. The 2018 FGI Table under Class 2, stipulates that where physiological monitoring and active life support is *anticipated* it shall be reviewed as a Class 3 imaging room. The 2022 FGI clarifies this language by allowing deep sedation in a Class 1 or Class 2 as long as the table requirements are met.
Discussion:

- RAC member asked for clarification on the types of sedation and their definitions. RAC member responded via Chat that NFPA 99 (2012) section 3.3.63 provides definitions for general anesthesia, deep sedation, minimal sedation and moderate sedation. **Follow-up – The following definitions were pulled from NFPA 99 (2012).**
    - 3.3.63.1 Deep Sedation/Analgesia

      A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. (MED)
    - 3.3.63.2 General Anesthesia

      A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-

induced depression of neuromuscular function. Cardiovascular function may be impaired. (MED)

- 3.3.63.3 Minimal Sedation (Anxlolysis)

A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. (MED)

- 3.3.63.4 Moderate Sedation/Analgesia (Conscious Sedation)

A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. (MED)

- FPS staff noted concern that the requested language states that *the facility* shall determine the imaging room classification. Concerns were noted that the functional program may describe a classification that doesn't meet what is actually happening. It was recommended that the language about the facility making the determination be omitted, while subparagraphs (a) and (b) were fine.
- RAC member agreed that the functional program cannot be the vehicle that determines what the review requirements are. It was noted that if someone is in an anesthetizing location, they must be providing other requirements. Sedation should not be 100% linked to the classification of the room.
- RAC member commented via Chat that classification should be determined by clearly established criteria, not just at discretion of project team developing the functional criteria.
- RAC member asked whether a cath lab or angio room qualify as a Class 3. Example provided of a cath lab that offers moderate or deep sedation, which raised concerns by MEP consultants based on NFPA and FGI table.
  - RAC member shared a facility that sets up their cath lab as a traditional O.R.
- RAC member indicated that design teams often rely on care teams to provide guidance. There is not only sedation but the invasive nature of procedures. It was suggested that clinical experts be brought in to speak to this particular issue. Do not want to stifle or create barriers for providers' ability to do procedures in an appropriate room.
  - B. Atkins asked RAC members to identify clinical experts that the OHA can consult with further.
- RAC member via Chat asked whether the 4-foot clearance noted under subparagraph (b) is measured from fixed elements only, or does this requirement include 4-foot clearance from moving elements, i.e. rotation arc of the gantry?
- RAC member noted that the functional program sets the stage for what the facility is doing but the OHA may request additional information. RAC member further noted concern with 4-foot clearance using MRI as an example. Via Chat,

RAC member stated, "For an MRI, the clearance should be around just 2 sides of the patient table."

- Via Chat, RAC member concurred with issues on clearance.
- B. Atkins noted that under the 2018 FGI, the rule is 4-foot of clearance on the patient transport path, and other clearances as required. In 2022, the FGI states "shall provide" and it doesn't matter what side. The subparagraph (b) is based on a cross reference with the 2022 FGI standard. It was noted that if there is an anesthesia machine in the room, there needs to be working clearances to be able to access the machine.

- B. Atkins noted NFPA requirements relating to anesthesia, and she further noted that since NFPA is a federal standard, the OHA does not have the ability to modify those requirements.

2.2-3.4.1.3 – Imaging Services – Radiation Protection
JRJ has requested under 2.2-3.4.1.3 (1)(d) to eliminate the requirement for a door between the cath lab control room and the treatment room. It was noted that under the 2022 FGI standard, the requirement for the door was removed, fluoroscopy or not. It is assumed that all cath labs are fluoroscopy. Discussion:

- RAC members concurred with fluoroscopy and proposed language.
- RAC member noted possible pressure differentials between rooms that would require a door between those spaces and will follow-up.

2.2-3.4.2.5 – Imaging Rooms – System Component Room
JRJ requested this standard be modified so the system component room not open into the imaging room or restricted space, for new construction or major renovation. Discussion:

- It was noted that prior to the adoption of the FGI, the equipment room was allowed to be opened into a Class 2 or 3 room making some existing facilities out of compliance with current standards.
- The proposed language would only apply to new construction or major renovation and not apply to equipment replacement.
- RAC members concurred with proposed language.

2.2-3.11.2.1 – Endoscopy Services – Endoscopy Procedure Room
FPS request to modify so that endoscopy procedure rooms do not need to comply with NRC requirements (previously discussed during July 17, 2024 RAC meeting). If a facility is required to or chooses to put in a hard lid for infection prevention, they do not need to meet NRC requirements. Discussion:

- RAC members had no comments.

2.8-1.1.1.4 – Mobile/Transportable Medical Units
Both OSHE and PKA requested that mobile trailers for purposes of Class 1 imaging not be subject to review (reference brief discussion on June 3, 2024) because these trailers are temporary and used for 180 days or less. Facilities still must comply with the requirements, but FPS will not review since the time required for review is longer than the time needed for the trailer. It was further noted that the 2026 proposed changes to FGI, for purposes of Class 2 and Class 3 mobile units, is considering the following language – *'2.8-1.1.4.1 2.7-1.1.1.1 (1) This chapter shall be applied to Class 2 and Class 3 mobile/transportable medical units that are used on a temporary basis. 2.8-1.1.4.2 2.7-1.1.1.1 (2) In the absence of state and local standards, "temporary basis" shall be defined as a period of time not exceeding six months during any 12-month period from the time procedures commence inside the mobile unit until the time procedures cease and it is transported off the host facility's site.'* Staff shared concerns with the 2026 proposed language based on additional types of temporary mobile units that might be used and that FPS would want to review. It was also noted that FGI's definition of 'temporary' does not align with NFPA 101 (2012). Discussion:

- RAC member noted that the OSSC/IBC also defines 'temporary' and should be considered for possible contradictions.
- RAC member asked, if a mobile unit was going to be used for longer than six months, would FPS be reviewing for compliance with FGI? Staff responded yes – any mobile unit that is used longer than 6-months will be reviewed and compliance with NFPA 101 (2012) required.

2.8-3.1.2 – Mobile Transportable Medical Units – Hand-Washing Stations
OHA is proposing to add language that for Class 1 mobile imaging units that do not already provide a hand-washing station, a hand-sanitation dispenser may be provided instead. It was noted that despite 2.8-1.1.1.4, this may apply to a Class 1 imaging mobile unit that is being used for longer than six months, and even though FPS may not review a mobile unit that is used for less than six months, facilities are still required to comply with the FGI standards. It was further noted that FPS has seen many mobile trailers in use that do not have hand washing stations. This would require a waiver, or a hospital would have to provide a stand-alone unit. FPS staff do plan to seek surveyor input. Discussion:

- RAC members had no input.

OAR 333-535-0015 – Physical Environment
Section (6) – Amendments to FGI standards excluded from review **for outpatient facilities.**

Samaritan Health Services has requested that Chapter 2.11 relating to outpatient psychiatric units be subject to review by FPS and added to rule. Currently, chapter 2.11 is excluded from review. It was noted that currently these types of facilities

are held to medical clinic standards which is an added cost and space allocation burden that is not needed no does it provide value to the public. Discussion:

- Several RAC members agreed that there is a need for these specific requirements for outpatient psychiatric centers.
- B. Atkins noted that any item shaded in grey was discussed previously on June 3, 2024 or July 17, 2024 and those meeting notes can be found on the FPS Rulemaking Activity page: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHCAREPROVIDERSFACILITIES/FACILITIESPLANNINGSAFETY/Pages/FPS-Rulemaking-Activity.aspx

OAR 333-535-0015 – Physical Environment
Section (7) – Amendments to FGI standards **for outpatient patient facilities**:

2.5-3.3.3.1 – Specific Requirements for Urgent Care Centers – Patient Care and Diagnostic Areas/Functional Requirements
Changes to the FGI requirements for hospitals in 2018 included allowing indirect (camera) observation in an emergency department that did not get included under outpatient facilities. Since emergency departments are a more critical care setting than urgent care, FPS program is proposing to add under outpatient setting.

2.11 – Specific Requirements for Outpatient Psychiatric Centers
Note – currently these centers would be reviewed under general outpatient clinics (exam rooms, soiled hold, toilets, etc.)

2.11-1.1.4 – Application
FPS is recommending that the following text be deleted: *The requirements in this chapter are not to be interpreted to inhibit placement of small neighborhood outpatient psychiatric centers (i.e., units with four or fewer employees) into existing commercial and residential facilities.* There are many entities in Oregon regulating behavioral health including OHA's Behavioral Health Division, ODHS (foster homes and IICs). This statement does not seem to add value. Discussion:

- RAC member asked what is an outpatient psychiatric center (secure residential treatment facility, residential treatment facility)? Staff responded that it is typically consult and group therapy where patients are free to come and go, but staff also noted that there are some questionable criteria that staff have concerns about that needs further discussion (e.g. electroconvulsive therapy, seclusion/secure hold rooms.)
- RAC member indicated that they have these types of facilities in Washington and looking at having them in Oregon as well. This is an opportunity to weigh in and would be helpful to have some guidance.
- RAC member indicated that psychiatric behavioral health did not meet the requirements of clean utilities, soiled utilities, EVS, etc. Want to ensure that

additional requirements are not added to outpatient facilities that don't apply to this specific facility type based on the type of medical services being provided.

***2.11-3.2.1.1 – Areas for Patient Services - General**
It was noted that the FGI language does not provide an absolute number for "clear path of escape." It was suggested that the appendix language under A2.11-3.2.1.1 be added into the rule text – "Space for a clear path of escape for staff. Furniture shall be selected and placed so that the staff member is always between the patient and the escape path or by providing two exit doors." Discussion:

- RAC members had no comments.

2.11-3.2.1.2 – Areas for Patient Services - General
The requirement is that there is a staff assist device to communicate with other staff, internal or external, when assistance is needed. FPS program is recommending adding VOICE communication to that specifics can be discussed.

- Advise that "communication" means two-way voice interaction, not just a button that beeps.
- RAC member asked whether verbiage could be added to allow secondary systems (dedicated system (not a personal cell phone), Vocera, etc.).

2.11-3.2.3 – Areas for Patient Services - Telemedicine Services
Staff noted that the program received feedback that the requirements under 2.1-3.4 are extreme and vague. The 2022 FGI standards cleaned up language to clarify it is telemedicine with other care providers, not the patient or public. Staff asked whether this section should be adopted. Discussion:

- RAC member via Chat indicated opposition to adopting telemedicine requirement. RAC member via Chat concurred.
- Staff noted that there was an initial effort to remove telemedicine from the 2026 proposed FGI standard but remained in. They further noted no objection to its removal.

2.11-3.2.4 – Areas for Patient Services - Consultation Rooms
OHA has recommended that language used in the appendix be added to the rule text stating that consultation rooms are used for one-on-one counseling or therapy. Discussion:

- RAC members had no comment.

2.11-3.2.4.2 – Areas for Patient Services – Consultation Rooms
OHA has recommended allowing facility staff to be able to have two-way communication (Vocera or similar).

2.11-3.2.7 – Areas for Patient Services – Seclusion Rooms

FPS staff will seek surveyor staff input on this standard. Concerns noted that since these standards are in the Outpatient book, how can rules be adopted that allow for restraint or locking an outpatient patient in a room against their will? OHA is recommending not to allow Seclusion Rooms in an outpatient psychiatric center *detached from a hospital*. If adopted, all of the standards noted under 2.11-3.2.7 would not apply. Discussion:

- Many outpatient psychiatric centers are proposed in business occupancy buildings. Persons not capable of self-preservation should not be seen in these types of buildings.
- RAC stated that a Seclusion Room needs to be in an inpatient behavioral health setting and agree that it should be removed from an outpatient standard.
- RAC member agreed that this function is best served in an inpatient setting. RAC member further recommended removing the language 'detached from hospital.' B. Atkins inquired about allowing a Seclusion Room if the outpatient center is withing the walls of a hospital or I-2 occupancy. It was suggested that looking at building codes further would be needed. A business occupancy classification does not fit well – persons may be held against their will and may be unable to protect themselves in case of fire. This is better suited for I-occupancy versus B-occupancy.
- FPS staff noted that patient rights and patient safety must be considered.
- RAC member also noted that safety of staff must also be considered. If an outpatient needs to be secluded, the patient is going to the wrong location.
- RAC member noted that the FGI chapter states that it's the safety risk assessment (SRA) that determines the need and it's the operators that determine the need. Rules needs to make it safe, and it may not be safe if the person cannot defend in place. Based on hospital code, probably not appropriate for how it's implemented, but the need may still be there if someone were to need it (de-escalation, prior to transport to an inpatient facility.) Someone would be needed to observe and assist in case of emergency. Staff responded that a "quiet space" could be used for purposes of de-escalation.
- RAC member noted this is not an emergency department drop off rather scheduled appointments and stated a quiet room makes more sense. (Reference standards for 2.11-3.2.8 for Quiet Room).

2.11-3.2.8 – Areas for Patient Services – Quiet Room

B. Atkins opened discussion noting that if a decision is made not to allow a Seclusion Room, should at least one quiet room be mandatory? Discussion:

- RAC member stated no. It was noted that in their experience most behavioral health clinics do have a quiet room, which is quite often used by staff to desensitize, have a break before going back to patient care.
- RAC member noted that there appear to be references that a consult room can double as a quiet room.

- FPS staff noted in considering the requirements for a Seclusion Room, perhaps some of the special design elements standards should apply to the Quiet Room for example avoid features that enable patient hiding, escape, injury, or suicide; walls designed to withstand direct or forceful impact; etc. If the room is being used to let someone calm down, need to ensure there is no opportunity to hurt self or others. If the Quiet Room is made optional, and a facility were to opt-in then these other requirements would need to be met.
- RAC member noted that the acuity level of the patient needs to be considered – these are patients with scheduled outpatient appointments, consults, check-ins. If the Quiet Room now needs to meet seclusion standards, why not just have a Seclusion Room. RAC should consider reducing the number of waivers and review time. RAC member further indicated they are not comfortable adding regulations and requirements to a Quiet Room that a person can walk out of. Patients being held against their will are usually on a type of hold, often transported by police or EMS due to mental health crisis.
- RAC member noted these are scheduled events in an outpatient clinic whereas patients in crisis are transported to emergency departments or other crisis facility for care.
- RAC members agreed that while some of the seclusion room criteria should be considered and implemented for patient and staff safety, it should not be regulated or subject to review by OHA.

2.11-3.2.8.2 – Quiet Room – Toilet Room
B. Atkins noted that FGI has used the term "resident" versus "patient." OHA will revise accordingly.

2.11-3.2.9 – Areas for Patient Services – Electroconvulsive Therapy (ECT)
B. Atkins indicated similar concerns as those noted under Seclusion Room including allowing ECT treatment to occur in outpatient setting in a building that is rated for business occupancy. FGI standards describe anesthesia, med-gases, nurse call, special electrical and need for CPR carts. Per internet search, "Electroconvulsive therapy (ECT) anesthesia typically involves administering drugs intravenously (IV) to put a patient to sleep during the procedure." Per CMS S&C-11-05-LSC, page 3 states that if a facility provides anesthesia services it must be classified as an Ambulatory Health Care Occupancy (reviewed with ASC ruleset for NFPA 101 compliance). OHA is proposing that ECT treatment is not allowed in outpatient psychiatric centers, detached from hospital, and therefore the FGI standards related to ECT would not apply. Discussion:

- Similar to previous request, 'detached from hospital' should be removed.
- RAC members had no further comment.

2.11-3.8.11 – Support Areas for Outpatient Psychiatric Center – Clean Storage

Samaritan Health Services noted that these centers are currently held to medical clinic standards which is an added cost and space allocation which is not needed and provides no value to the public. OHA staff asked whether rather than requiring a clean storage room, perhaps a clean storage 'area' should be considered by matching language found under 2.12-3.8.13.1 (physical rehab) clean and soiled linen storage? Discussion:

- RAC member requested additional information on what is meant by 'area' – clean hold? cart with a cover? B. Atkins responded that FGI glossary defines as a space to contain the subject that can exist within another space or room. In this case, a clean supply area could be case work, an alcove, part of another room.
  - FPS staff noted that an 'area' could be subject to tampering or theft. and asked whether additional language is needed in terms of the location of the area or perhaps the area needs to be under staff supervision due to possible theft, nuisance, etc. RAC member via Chat indicated that 'under staff supervision' is tricky verbiage and asked whether a locked room in a hallway qualifies as 'staff supervised' if it's not directly observed?
- Question raised what clean supply is needed for outpatient psychiatric center when just talking with a patient? B. Atkins shared that what may be put in, for example a cabinet, is up to the facility – but at least the facility is capable of storing. Provided example that clinic may offer warm blankets during therapy session. RAC member asked whether more current versions of FGI may address this further. Requirement doesn't seem relevant. FPS staff will review 2022 and proposed changes to 2026. RAC members via Chat concurred indicating the following:
  - Not sure there are any clean supplies or linens in behavioral health outpatient clinics; mostly "talking rooms."
  - Behavioral health clinics tend to have minimal supplies (limited to a first aid kit and a defibrillator). No bandages, medications, etc.
- RAC member questioned whether any ventilation requirements are triggered by the clean requirements under FGI or ASHRAE 170 which brings up other possible issues.
  - RAC member shared via Chat that ASHRAE 170 lists ventilation requirements for Clean Workroom or clean supply, but it does not have requirements for clean areas within the other room.
- Question raised by RAC member where supplies are held (assuming from clean supply) if a psychiatric behavioral health center has an exam room. B. Atkins noted that possible language could be, where an exam room is provided then there shall be a clean supply room.
  - RAC member noted that in these centers they are not exam rooms, rather consultation rooms. It is unlikely that there will be an exam table in this room.

RAC member via Chat indicated there is no exam table provided in their behavioral health clinics; only soft furniture. (Picture of room was emailed to RAC members.)

- Behavioral health assessment may occur in an exam type space was shared by RAC member.

- RAC members generally agreed that a dedicated clean supply room is too stringent, a clean supply 'area' is acceptable, and all centers around whether an exam room is provided.

2.11-3.8.12 – Support Areas for Outpatient Psychiatric Center – Soiled Holding

Similar to clean storage discussion, OHA proposes to specify 'Where an examination room is provided or when biohazardous waste is generated, See Section 2.1-3.8.12 (Soiled Workroom or Soiled Holding Room) for requirements for soiled holding." Discussion:

- RAC members had no further comments.

2.11-3.8.13.3 – Support Areas for Outpatient Psychiatric Center – Equipment and Supply Storage; Wheelchair Storage

B. Atkins noted that the cross reference indicates that the clinic needs to provide wheelchairs and needs to provide space away from the public to store the patient's wheelchair. Based on previous discussions, it is likely that patient's will stay in their wheelchair or other mobility device for their comfort. Dedicated wheelchair storage, therefore, may not be necessary. Discussion:

- RAC member indicated they assumed the patient would stay in their wheelchair throughout their consultation.
- May hinge upon exam room.

2.11-3.9.1.1 – Support Areas for Staff – Staff Lounge and Toilet Room

Samaritan Health Services noted that these centers are currently held to medical clinic standards which is an added cost and space allocation which is not needed and provides no value to the public. B. Atkins shared that an outpatient medical clinic does not require a staff lounge and that requiring would be an added expense and allotment of square footage. An outpatient clinic also does not require a dedicated staff toilet. Discussion:

- FPS staff shared that a staff lounge would be good for respite, and it was noted earlier that many staff use the Quiet Room. Perhaps this is a compromise to require a Quiet Room.
- B. Atkins proposed that if both a Seclusion Room and staff lounge are optional, perhaps a Quiet Room should be mandated. RAC member questioned how the room could be scheduled if its multipurpose. RAC member asked if there was any commentary that could be referenced.
- RAC member indicated the staffing profile must be considered. With exception of possible receptionist, many services are 1:1 with the counselor bring the patient back to the room. It was questioned whether the exam room is being used by

the provider as their office. It's about taking away respite, but the staffing profile needs to be considered to see if a staff lounge is actually needed and should be addressed in the functional program. It should be optional. RAC members concurred via Chat.

- Small and large group therapy sessions are likely held at these facilities so there may be higher stress; more intensive programs lead to higher level of stress and depends on the facility which would advocate for a staff lounge.

2.11-5.2 – Building Support Facilities – Waste Management

B. Atkins noted that the cross reference will require a secure space for regulated medical waste and other regulated waste types. Given previous feedback, it is not clear what medical waste will be generated. OHA is proposing that text be amended to reference section 2.1-5.2.1 for waste collection and storage for requirements and section 2.1-5.2.1.3 will only be required if an exam room is provided or biohazardous waste is generated. Discussion:

- RAC members had no comments.

2.11-5.3 – Building Support Facilities – Environmental Services

Current language requires an environmental services room. With or without clinical care, these spaces still must be cleaned. Discussion:

- RAC members had no comments.

2.11-6.2.1.1 – Public and Administrative Areas – Entrances

Current language requires that entrances be secured at least at the outpatient psychiatric center. B. Atkins noted that these are outpatients and as such patients are not being held against their will. Uncertain whether the intent of the requirement is to lock people in, or lock people out. Discussion:

- RAC member shared that at their facility the provide the means to lock-out a patient from entering space through use of a remote locking function at reception area (phone threat, patient physically agitated, etc.).
- Question was raised about locking a potentially violent person out from entering the building, would they just go to the next clinic? RAC member responded this comes up in a multi-tenant space and the landlord doesn't have ability to lock entire building down. There is no means to enforce a building wide lock down when there are multiple tenants.
- RAC member via Chat indicated that facilities would want the ability to lock people out. It's a staff/security issue. Unhappy patients or family members could theoretically show up with a gun.
- RAC member indicated locking patient out allows time for someone to call security for help.
- RAC member questioned whether this is requirement or allows ability to make decision with staff during design to have that option. B. Atkins noted it's

currently a requirement until changed. RAC member reiterated need to discuss with physician group to determine if needed.

- RAC member noted that the standard does not describe which door or how to secure. Access to rest of clinic may be by key code to prevent disruption spilling into therapy spaces. Could also be front door based on service area and there should be flexibility on how to implement.
- RAC member stated this needs to be identified in the SRA.
- RAC member noted that the clinic could be in the middle of a mall and can really only control access to the clinic.
- FPS staff noted that the language calls out "at the outpatient psychiatric center" and does not call out other entrances.
- RAC member provided example of clinic being worked on where the building has both pediatric and adult behavioral health patients. Metal detection and security guards are at front. Another clinic is internal to a specialty medical office building where part of entrance is through hospital and then into the medical office building and then to clinic. Don't disagree with assessment that it needs to be done, but the organization needs the ability to be able to control the situation based on operational narrative.

2.11-6.2.1.2 – Entrances (continued)

FGI standard indicates that where entrance lobby and/or elevators are shared with other tenants, travel to the outpatient psychiatric center shall be direct and accessible. Except for passage through common doors, lobbies, or elevator stations, patients shall not be required to go through other occupied areas or outpatient service areas. Discussion:

- RAC member inquired whether this means that patients cannot go through common areas before the clinic? B. Atkins noted language indicates that passage can be through common doors, lobbies or elevators to access the clinic. FPS staff noted that under public areas it refers to 2.1-6.2 which states, "Building entrances used to reach outpatient services shall be located so that patients need not go through other activity areas (shared lobbies shall be permitted in multi-occupancy buildings.) Common areas are okay but cannot go through clinic A to gain access to clinic B. Staff further suggested that the locking requirement be stricken and allow the facility to determine need. Other staff noted that staff safety needs to be considered and is probably why the language is there.
- RAC member noted that in smaller communities there are many financial constraints and the experts in behavioral health need to consider environment, level of care, and location to help drive need; it's an operational staffing plan on how to manage these situations. Impacts and needs in rural environments may differ, and critical access hospitals need to be considered.
- RAC member noted that trends in rural health care are driving towards centralized check-in to reduce staffing overhead in smaller clinics where providers are only practicing a few days a week and reception is being shared across multiple clinics. Half licensed space and half rural health clinic (RHC) in one building where separate reception areas are required. Needs to be evaluated

by the facility – who is staffing reception? What clinics are they managing? Is there another desk next to them serving another clinic that may create a communication issue? There may be additional RHC requirements that need to be considered. It's better assessed through the functional narrative.

2.11-6.2.2.2 – Public and Administrative Areas – Reception
FGI standard requires the reception/information counter or desk to be located to allow 'visual observation of the entrance…' B. Atkins asked if cameras are acceptable or should it be by direct visual observation? Discussion:

- RAC members had no comments.
- FPS staff noted that hospitals allow indirect observation of waiting/entry rooms.

2.11-6.2.3.1 – Public and Administrative Areas – Waiting Areas
Language states that the waiting area for patients and escorts shall be under staff control. Use of term 'escorts' seems confusing as it may imply police. B. Atkins questioned if it should be removed. Discussion:

- RAC member indicated that it likely means 'family member' as police should not be transporting to outpatient clinic.
- Staff suggested removing 'patients and escorts' altogether.

2.11-6.2.3.2 - Public and Administrative Areas – Waiting Areas (continued)
Language states where the outpatient psychiatric center has dedicated pediatric service, a separate controlled area for pediatric patients shall be provided. B. Atkins expressed concern because an 'area' is a space within another room. Is enough being done to protect pediatric patients?

- RAC member indicated that pediatrics should be separated from adults including separate entrances and non-shared waiting areas. A RAC member via Chat indicated that even adolescents should be separated from pediatrics.
- FPS staff concurred and noted that in psychiatric hospitals adults and pediatrics are completely separate.
- RAC member noted that parents may accompany a child while receiving services at these clinics. A common entrance is used into the clinic, meet in the reception area and then separated into two different lobbies (one for adult and one for pediatric child and family). Occasionally they will be physically separated with either a door or transparent gate that keeps children contained in an area, so they are not comingling in a patient waiting area. They are physically separated into two different areas in the waiting area.
- FPS staff noted that having two separate doors does not make sense because outside those doors they are comingling in shared space. It was further asked what is "dedicated pediatric service?" Does this mean it's a facility with four therapists where only one serves pediatrics? 50/50? How are plans examiners going to be able to apply the "dedicated pediatric service"? If the function program indicates that a pediatric patient is served, will the standard need to be

met? Should language be updated to 'where the outpatient psychiatric center *provides* pediatric services in addition to adult?'

- RAC member stated concern about requiring two separate facilities when the volume of patients in rural areas may not need that.
- RAC member indicated that in rural communities their behavioral health is the ED and are being expanded to take on more behavioral health. Mixing behavioral health pediatrics and adults is unacceptable. Spaces to provide support to both those types of clinics is fine, but they need to be separated. Operational changes should be considered such as adults seen on Mondays, Wednesdays and Fridays and pediatrics on Tuesdays and Thursdays, or perhaps different hours.
- RAC member stated that allowing operational changes such as days of week or different hours is a tool that can be utilized to manage patient population and physically separate the population. This may also better serve rural communities by allowing flexibility and eliminating the need to have multiple different physical spaces when the volume of patients does not support.
- RAC member via Chat indicated they feel like that approach may be better suited for critical access facilities where the patient volume may not allow for completely separate facilities.

2.11-7.1.2 and 2.11-7.1.2.1 – Design and Construction Requirements – Security

FGI standard indicates that observation of all public areas, including corridors, shall be possible and that observation can be accomplished by electronic surveillance if it is not 'obtrusive.' B. Atkins noted that the term 'possible' is not enforceable and the term obtrusive is subjective. Discussion:

- FPS staff recommended removing 'if it is not obtrusive.' Electronic surveillance is everywhere. Other staff indicated that perhaps it was meant to address public toilet rooms.
- RAC member this needs to addressed by the SRA.
- RAC member via Chat suggested the following language - hidden alcoves and blind corners in corridors shall not be permitted.

2.11-7.2.2.1 – Design and Construction Requirements – Tamper Resistance and Suicide Prevention

The FGI standard indicates that standards under 2.1-7.2 must be met and where the SRA identifies suicide risk or staff safety concerns, the ceilings, walls, floors, windows, etc. shall be tamper-resistant in patient treatment areas. B. Atkins noted that tamper resistant ceilings will require locked access hatches and no lay-in ceilings tiles that can be moved, thus requiring a hard lid. It was further noted that requiring rods, doors, grab bars, and handrails to be constructed to not allow attempts at suicide nor can be used as weapons in another standard that will be difficult to adopt. This is an outpatient setting where patients can leave the clinic and could find other risks around them. Discussion:

- RAC member noted that this patient population will not be unattended in an exam room. These are consultation spaces. This requirement does not make sense. The one area that may need to be considered based on risk is the restroom.
- RAC member noted that based on verbiage, the higher-level standard is not required unless the SRA identifies suicide risk or staff safety concerns. B. Atkins noted that this information is rarely shared and thus hard to enforce.
- FPS staff further noted that "ceilings, walls, floors, windows, etc., shall be tamper-resistant in patient treatment areas" is vague. Ligature resistant grab bars can be put in the bathroom because the SRA notes a suicide risk, but the floor drain in the bathroom doesn't get changed out to an anti-ligature grate. If the Quiet Room is not required to have seclusion room requirements why enforce these others?
- B. Atkins noted that this could be removed from rule and the design team could voluntarily provide. FPS staff concurred and noted the facility would need to decide what to do to reduce the risk.

2.13-1.1.2.1 – Mobile Transportable Medical Unit

B. Atkins noted that given that Section 2.8 was not adopted there is a broken cross reference. The text would state, "A single-patient exam room for specialty clinical services as described in Section 2.1-3.2 (clinical service rooms.) This is the closest fit in rules that were adopted. Discussion:

- RAC had no comments.

2.16 – Specific Requirements for Sleep Disorder Centers

B. Atkins noted that FPS reviews a lot of sleep study clinics and in absence of specific rules, the program has reviewed under the general medical outpatient clinic. The proposed 2026 FGI guidelines has proposed adopted a new chapter for sleep study clinics. Does the RAC wish to consider early adoption?

- RAC asked whether these were outpatient? B. Atkins stated yes. It was further noted that all of the standards identified are more stringent than the general outpatient requirements.
- RAC members concurred to not adopt.

Next Steps
Need to have one more meeting to consider final changes based on RAC discussions and review possible fiscal and equity impact. M. Bernal reminded RAC members to complete the meeting poll that was forwarded by email. **Follow-up: Based on responses to meeting poll, the FPS Project Review RAC is scheduled to meet again on September 24, 2024 from 9am until Noon.**

RAC concluded at 12:03 pm