FPS Project Review Rule Advisory Committee
September 24, 2024
9:00 AM – Noon via Zoom

RAC MEMBER ATTENDEES	
Aaron McGarry	GMA Architects
Barbara Hansen	Oregon Palliative Care & Hospice Association
Barbara Tauscher	PMPCI
Chris King	Fresenius Medical Care
Elaine La Rochelle	Grande Ronde Hospital
Janice Sanada	LRS Architects
Jeff Taylor	Providence Health & Services
Jeremy Stremme	Legacy Health
Jon Anderson	AD Architects
Jon Mehlschau	SRG+CannonDesign
Kelly Chanopas	ZGF Architects
Kristin Videto	Davita
Marcy Pierce	Asante
Matt Ottinger	JRJ Architects
Matt Stormont	PeaceHealth
Naomi Mathaba	OHSU
Sarah Kershner	PKA Architects
Scott Combs	CKA Architects
Tim Clem	OSHE

Oregon Health Authority (OHA)/Department of Human Services (ODHS)	
Barbara Atkins	OHA-PHD-Facility Planning and Safety Program
Jeremiah Adams	ODHS-Nursing Facility Licensing
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
Sean Scott	ODHS-Nursing Facility Licensing
Shane Jenkins	OHA-PHD-Facility Planning and Safety Program

Welcome and Housekeeping

Mellony Bernal introduced self and welcomed attendees to the fifth rule advisory committee meeting where the committee will consider 'hot topic' issues previously discussed and review the Statement of Need and Fiscal Impact, including any potential racial or equity impacts as a result of the proposed rule changes.

- A brief overview of the previous meeting topics was shared:
  - May and June RAC meetings focused on changes to the project review process under OAR 333-675.
  - July RAC meeting focused on amendments to the FGI standards for Special Inpatient Care Facilities, Ambulatory Surgery Centers, Extended Stay Centers and started to review the standards for hospitals.
  - August RAC meeting completed the review of proposed changes to hospital standards including outpatient facilities.
- Attendees were asked to enter their name, title and organization into the Chat.
- It was noted that the RAC meeting would be recorded and that the recording and information shared in the Chat was public record and therefore subject to disclosure.
- Staff will be entering live comments on the rule document 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.
- Pursuant to the OHA policy, members of the public may attend but may not participate or offer public comment during the meeting.
- 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 comment as well as written public comment.
- The goal is to have final proposed rule language to the PHD Rules Coordinator by November 15, 2024, and hold a public hearing in mid-December. Failure to meet this deadline may result in rules not being filed until June 2025 given the Public Health Division's policy on not holding public hearings during legislative session.

Administrative Rule Review

OAR 333-535 and 333-675 – Review of Hot Topics from Previous RAC meetings

Barbara Atkins shared via Chat the hot topics that will be discussed.

- FGI standards: Medication Safety Zones (pages 11-12)
- FGI standards: Anesthesia in Class 1 imaging; anesthesia in Class 2 forcing it to be Class 3 (pages 15-16)

- FGI standards: Renovations, 'Affected Area' (pages 8-9)
- OAR 675: Definitions: remodel vs renovation, impacted and affected areas, etc. (pages 2-3)
- OAR 675: Waivers, create a list that can skip full waiver process (pages 25-26)
- OAR 675: Fee when reopening a closed project (page 14)
- OAR 675: Project Valuation Threshold (pages 7-9)

RAC members were encouraged to raise any additional hot topic issues they have for discussion.

OAR 333-535-0015 – Physical Environment

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

2.1-2.8.8.1 – Support Areas for Patient Care Units and Other Patient Care Areas - Medication Safety Zones

B. Atkins shared summary of previous discussion including understanding difference between medication preparation, medication dispensing and medication administration and the need to clear up language. Additionally, issues concerning light levels and eye fatigue were discussed, including where light level measurements should be taken from (at work surface, every component of the zone which includes handwashing station, work surface, area in front of medication dispensing unit, etc.). RAC members were asked whether they had any new comments or ideas for possible language.

Discussion:

- RAC member via Chat questioned whether the medication safety zones are limited to a 2' by 2' area size where task lighting at 100 ft candle is required. B. Atkins asked the RAC member whether they had any suggestions on where the measurements should be taken from) since there is some vagueness in the FGI on where these measurements are taken. RAC member shared that it is unlikely that a person is reading a prescription from point A to point C, and measurements should thus be taken at the worksurface versus multiple points.
- Staff noted that FGI sets the minimum standard and it is up to FPS staff to interpret that minimum standard for patient and staff safety. It was further noted that the standard includes how the USP defines medication safety zone. Staff noted that rules may likely reference medication dispensing areas and medication preparation rooms and may remove medication administration, which causes further confusion.
- Via Chat, RAC members stated:
    - Hoping any amendments clarify the different requirements between med dispensers and med prep zones.
    - One of the concerns was a medication dispenser (i.e. Pyxis), to what extent is the zone that is measured in front of it? The countertop is a more

easily defined zone, so more definition for specific areas to be measured would be supported.

2.2-3.4.1.2 – Imaging Services, Imaging Room Classification

B. Atkins summarized previous RAC discussion and noted that per the Table reference in FGI, the use of anesthesia in a Class 2 imaging room forces it to become a Class 3. The biggest concern relating to a Class 2 to a Class 3 is Cath labs. Language has been updated to align with the 2022 FGI standards as it will allow anesthesia in a Class 1 if specified requirements are met. It was noted that the MEP contractor was contacted to identify whether there are any concerns with adopting the language. A new subsection has been added since the last RAC meeting that identifies what the MEP review team will be assessing.

> "(b)(f) Compliance with NFPA 99 and ASHRAE 170 requirements for anesthetizing locations is required no matter the imaging classification. Conformance includes but is not limited to ASHRAE 170 article 7.1(a)(7), ASHRAE 170 Table 7.1 note m and p, NFPA 99 articles 5.1.5.16, 5.1.4.8.7, 5.1.9.3, 6.4.2.2.4.2, 6.3.2.2.11.1."

B. Atkins reminded RAC members that the state has the ability to modify standards related to the FGI, however, it does not have the ability to amend the federally adopted NFPA standard.

Discussion:

- RAC member via Chat stated agreement with ASHRAE 170 but not FGI requirements for room sizes. They further stated that many hospitals are moving anesthesia to different places within the hospital, including patient rooms, which technically creates a 'change of use.' It was noted that anesthesia is frequently moved into the MRI room and the room size requirements of four-foot clearance on all sides is concerning. Staff responded that if using an anesthesia machine or if emergency response is needed, the clearance requirements would be reasonable to care for the patient.
    - RAC member stated that if a patient codes, the patient should be immediately removed from the room into an adjacent space for resuscitation.
    - Consider possible MRI exclusion but what about PET CT for anxiety or pain management and clearance necessary.
    - RAC member noted that often lower-level sedations are administered through I.V. and therefore the anesthesia machine is not necessary. Clarification was requested regarding bed clearance requirements for imaging rooms versus work clearance around anesthesia machines. It was noted that some leniency has been granted in the past for an MRI because some clearances cannot be achieved at the bore. Staff responded that for imaging rooms wishing to include anesthesia services, 4 feet is required on

all sides unless the bore is against a wall. RAC member further stated that the sedation type may lend itself to different work clearance requirements.
    - Conversion of a room to accommodate anesthesia is a big issue. Staff noted that per the 2022 FGI, clearance requirements are necessary when using an anesthesia **machine** and would not be necessary if anesthesia is through an I.V.
- Staff raised that under FGI, Table 2.2-2, specific language under Class 3 imaging room has caused MEP reviewers to state that a Cath lab is a Class 3 room not Class 2 - The language included with table under the heading 'Class 3 imaging room' states, "Any Class 2 procedure during which the patient will require physiological monitoring and is anticipated to require active life support."
    - RAC member stated the MEP interpretation of the Table means there are likely only Class 1 and Class 3 rooms, which poses the question of why Cath Labs are identified in the Class 2 chart. Staff responded and asked if the suggestion was that language be changed identifying that a Cath Lab is a Class 2 room as the minimum standard unless identified otherwise by the project team. RAC member noted issues that must be considered, including sedation level, invasive nature of procedure, and whether patient is high risk. Cath Labs are challenging based on how the term semi-invasive is described. Changing out equipment should not require a change in classification type. Class 2 imaging should be clearly defined but needs to separate out any MEP triggers. It was noted that space types need to be provided based on clinical need and facilities should be allowed to make decisions on their use. The care team needs the flexibility to allow medicine to progress while still holding them accountable for not jeopardizing patient safety.
    - Staff stated that per FGI discussions, Electrophysiology procedures (EP) is Class 2. Facility needs to decide what they want the space to be capable of, the acuity and risk of the procedures performed, and opt to be more than a Class 1 or Class 2 when desired.
    - Possible language posed by staff, "Any Class 2 procedure that is not EP or Cath Lab during which the patient will require physiological monitoring and is anticipated to require active life support." It was further noted that interpretive guidance could also be considered.
    - RAC member noted projects where a Cath Lab was designed as a Class 3 in case a patient codes and results in invasive procedure. It was further noted that Class 2 = unrestricted and semi-restricted areas and Class 3 = restricted, semi-restricted and unrestricted areas.

1.1-3 – Renovation

B. Atkins noted that the topic of renovations overlaps both OAR 333-535 and OAR 333-675. During previous discussions, the RAC discussed elaborating on renovation projects and how FPS reviews them, including discussing how to define affected areas.

- RAC member remarked that language needs to be identified that will eliminate the back and forth that currently happens with MEP reviewers regarding existing

licensed facility and existing systems. Example provided of more than 60 days of back and forth with MEP reviewers for confirming an existing system that does not impact the scope of the project. The process needs to be streamlined and a clear delineation of what an existing system requirement might be to alleviate time being lost on these projects. Several RAC members concurred via Chat.

- Staff commented about exploring a possible attestation process whereby the facility attests that the system is existing and met previous requirements.
- RAC member via Chat indicated they are working on proposed language for definition of "affected area" which will be shared with RAC members once received.
- RAC member noted that exchanging medical equipment will affect MEP and FGI requirements (med gas, electrical, etc. within the room), but at issue is when this exchange of equipment requires changes outside the room, including clean utility, janitor's closet, toilet room, etc. which is beyond the scope of the project. A change of use in rooms that meet FGI and ASHRAE 170 requirements should not be required to be reviewed beyond the change of use.
- Staff shared that for purposes of FPS review, a conversion is changing the licensure category or licensing something that hasn't been licensed yet. Examples - apartment building that wants to be a licensed RCF; a house that wants to be a freestanding birthing center; an ASC that wants to become a hospital licensed outpatient surgery center. RAC member noted that a conversion is a change of use. Discussion ensued regarding possible fee implications (tax assessed value of the portion of the work that is changing its use; in absence of tax assessed value, must refer to the ICC document that discusses industry value valuation of category types.)
- RAC member via Chat indicated that per FGI 1.1-3.2.1, "Affected Areas, only that portion of the total facility affected by the project shall be…"
- RAC member shared example of going beyond the four walls of a project - existing licensed emergency department where project involves installing a Pyxis machine in part of the department. The wall is being removed to open the meds area into the hallway since the meds will be secured in the Pyxis. Reviewer is asking for information about the trauma rooms which is in a completely different area of the department.
- RAC members were encouraged to submit proposed language to staff for consideration.

OAR 333-675-0240 – Waivers

B. Atkins noted that based on previous meetings, RAC had suggested that this rule include a list of items that can skip the waiver process. RAC members were asked to share those items that should be excluded from requesting a waiver. The following items were identified:

- Equipment replacement and clearances;
- Temporary imaging trailers on site for 180 days or less;
- For equipment replacement, allow an existing electrical equipment room accessible through a Cath lab to remain in place;

- All previously approved waived items from facilities. Staff expressed concern and noted that waivers should be considered on a case-by-case basis except those items that are common amongst all facilities;
- Health service returning to hospital;
- Sink paddles vs hand free faucets in dialysis PD training room clean sinks;
- Via Chat, eliminate requirement for floor drains in Soiled Utility rooms which is an infection control issue according to facility's infection prevention department. It was noted that before FGI was adopted the FPS program required floor drains in these rooms. FGI does not require these floor drains. Do project reviews need to be submitted if FGI eliminates a requirement that was subject to review previously?

RAC member posed question about whether a request for a waiver is needed when it is believed that a project does not need to be reviewed (example – request to not have a hyperbaric chamber being returned to hospital subject to project review; with no response after three months, the project was shut down.) Staff noted that there is a difference between a request for a waiver and request to determine no review is needed. Waivers are tied to a project by their project number, whereas a 'no review letter' is not. Requests for no review should include why the facility believes no review is needed. Staff noted that current rules describe projects that are subject to review and when they can be "waived" [OAR 333-675-0000(2) and (3).] It was noted that the term 'waived' that is used under current rule should not be reflected in revised rules and a different term identified so that the process does not trigger need for waiver process (e.g. 'exception', 'excused', etc.)

B. Atkins remarked for projects that may qualify for review because of the valuation threshold but involves, for example, replacing all sinks in facility, or all carpet, it may not be best use of time. If the project is like-for-like, perhaps an attestation process may be considered.

OAR 333-675-0150 – Expiration of Projects

B. Atkins summarized previous discussion relating to what fees may apply when reopening projects that have been considered inactive and what rules may apply. Staff noted that should projects need to be re-opened, the fees and standards in place at the time a project is re-opened, will apply. It was noted that due to acute and long-term care facilities response to the COVID pandemic, the FPS program has not been closing projects. Some of these projects were reviewed under the previous rules prior to adoption of FGI and should they be re-opened, they would need to comply with FGI.

- RAC member asked staff to clarify how a project is closed. Staff noted that there are two options – 1) the facility contacts FPS and states the project should be closed; 2) when the facility stops corresponding with FPS staff. RAC member responded that a clear timeline needs to be specified and followed. The project should be closed and if the facility wants to re-open, they are subject to the fees and standards that are in place. (Note specific timelines identified in rule.)

- Staff noted concern that workload may increase based on notifications that projects will be closed. There are currently around 300 projects that are considered inactive in the last four years. Staff indicated that notifications will be a phased approach. RAC member shared that FPS staff time is valuable, and an automated approach would be great.
- RAC members indicated via Chat support for deadlines and one notification from the program that the project will be closed if there is no response from the facility.

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

B. Atkins summarized that per previous conversations, the FPS program is considering the project valuation threshold. Staff are unable to identify how the amounts were initially conceived. It was noted that Andersen Construction had submitted a Construction Cost Index summary that had been reviewed previously suggesting a threshold of approximately $150,000 (current rule is $50,000). B. Atkins further noted that it may be feasible to adopt a valuation threshold in rule that covers several years until the next opportunity to reopen rules and extend the timeline. Staff asked for RAC member input on the valuation threshold.

- RAC member suggested a threshold of $250,000 which was supported via Chat by other RAC members.
- RAC member via Chat expressed that the threshold is direct construction cost, no medical equipment or FFE (furniture, fixtures, and equipment).
- RAC member expressed concern about projects that are below the threshold but include a Fire Life Safety (FLS) component which should constitute a mandatory review. Question was raised by other RAC member about local AHJ review. Staff noted that projects submitted today would be submitted under the 2022 OSSC, which adopts the 2019 version of NFPA 13 and 72 which the local AHJ would be reviewing. CMS has adopted the 2012 edition of the NFPA 101 which adopts the 2010 version of NFPA 13 and 72. The local AHJ is not reviewing the same requirements as the health care team at the State Fire Marshal's office. Staff further acknowledged awareness of survey citations related to FLS.
- Staff noted that per current rules, there is a requirement that any alteration or addition to an existing facility or constructing a new facility must submit projects for review to FPS **and** for compliance with NFPA standards. Thus, if systems are being changed that affect FLS, they must be submitted to FPS for review.
- RAC member asked how to navigate FLS when there are only minor modifications, perhaps some form of attestation. Staff responded that facilities could email FPS staff the question which is forwarded to the health care team for review for purposes of determining whether a review is needed.
- Another RAC member via Chat indicated that barrier remediation (repair maintenance) does not seem like it rises to the level of FPS review.
- RAC member added that like-for-like equipment replacements may have a minor modification affecting FLS that should also be considered when considering rule language previously discussed.

- RAC member via Chat expressed support for a $250,000 threshold for projects that don't affect FLS systems. $150,000 seems low and would result in submission of almost all projects.
- Staff asked RAC members to share any evidence that suggests the $250,000 threshold is appropriate.
- Clarity on finish replacements or repair maintenance upgrades should be considered. The monetary threshold is quickly met when replacing, for example, all carpet at one time.
- RAC questioned whether the inclusion of ICRA would require a review if monetary threshold and FLS do not apply.
- RAC member via Chat suggested that commentary be added to the Plan Review Guidebook such as the definition of review area and workflow with State Fire Marshal's office on minor FLS work.

Additional hot topic issues raised:

B. Atkins shared that an ASC is required to have ice machines per FGI Chapter 2.7 which would also be required of an ASC that performs only endoscopy services which is also reviewed under Chapter 2.9; thus, ice would be required in an endoscopy center.

- RAC member noted that ice is not given to endoscopy patients and thus the requirement makes it challenging for endoscopy ASCs that don't want or need ice in patient recovery areas. If a patient wants liquid refreshment, a water dispenser is available.
- It was suggested that under the 2.7 rules, exclude ASCs providing only endoscopy services which would eliminate another common waiver.

Phone and water accessibility was raised as another possible issue. Staff noted that these are required in both acute care facilities and long-term care facilities for purposes of patient dignity as well as for caregivers.

- RAC member indicated that access to water fountains creates issues for endoscopy centers due to NPO status ("nothing by mouth") for patients and risk of aspiration under anesthesia. Ready access to water is difficult for patients who may forget and results in delayed procedures.
- It was requested that having signage available that water and phone is available upon request be instituted in place of mandatory requirement. Access to a landline phone when cell phones are readily available needs to be reconsidered.
- Staff noted that signage is allowed and noted that tethering a phone to a cord creates confidentiality concerns and cordless phones should be considered.
- RAC member acknowledged that some of the aging population may not have cell phones; however, given the number of people who do have cell phones, guidelines should be changed to reflect what is truly out there in society.

Statement of Need and Fiscal Impact

M. Bernal reviewed the Statement of Need and Fiscal Impact including the following:

- Need for the rules;
- Documents relied upon;
- Statement of possible racial equity impact;
- Fiscal and economic statement; and
- Costs of compliance for small businesses.

RAC members had no suggested changes.

Next Steps
RAC members were given a deadline of October 14, 2024, to submit any final suggested revisions or draft rule text to mellony.c.bernal@oha.oregon.gov. FPS staff will consider proposed changes and consider information shared over the last several months and will make final proposed changes to rules. The goal is to have final proposed rule language submitted to the PHD Rules Coordinator by November 15th and to schedule a public hearing in mid-December with an anticipated final rule adoption by mid-January. Staff thanked RAC members for their ongoing involvement in this RAC process.

RAC concluded at 11:48 am