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Hospice Program Licensing Rule Advisory Committee
September 28, 2022
1:00 – 4:00 p.m. via Zoom

RAC MEMBER ATTENDEES
Barb Hansen, CEO, Oregon Hospice and Palliative Care Association
Barbara Ju, Policy Analyst Nursing Assistant Education and Assessment, Oregon State Board of Nursing
Bernadette Nunley, National Director of Policy, Compassion and Choices
Christina Jaramillo, Exec. Director, Accent Care Hospice and Palliative Care of Portland (Substitute for Kate Brewington representing Oregon Association of Home Care)
Eugenia Liu, Oregon Health Care Association
Iria Nishimura, Executive Director, Willamette Vital Health
JooRi Jun, CEO, Oregon Nonprofit Hospice Alliance
Kristi Youngs, Chief Clinical Operations Officer, House call Providers
Mary Kofstad, President, Signature Healthcare at Home
Rochelle Webster, Quality Control Program Manager, Asante Hospice
Tracy Villarreal, CEO, Care Partners Hospice

Oregon Health Authority Staff	
Anna Davis	Public Health Division, Health Facility Licensing & Certification
Lori Barfield	Public Health Division, Health Facility Licensing & Certification
Mellony Bernal	Public Health Division, Health Care Regulation & Quality Improvement
Sosena Samson	Public Health Division, Health Facility Licensing & Certification
Teri-ann Stofiel	Public Health Division, Health Facility Licensing & Certification
Zachary Goldman	Health Policy & Analytics Division, Office of Health Policy

Welcome, Housekeeping and Agenda Review

Mellony Bernal introduced self and welcomed attendees to the Hospice Program Licensing Rule Advisory Committee (RAC). The following housekeeping items were reviewed:

- Attendees were asked to enter their name, title and organization into the Chat and identify whether they are a RAC member, member of public, or an Oregon Health Authority (OHA) employee.
- Attendees were asked to keep devices muted until called upon.
- RAC members were asked to type the word "Comment" to indicate they want to speak to a particular issue or ask questions. RAC members who do not necessarily want to speak but want the agencies to consider information were asked to type into the Chat “For Your Information” or “For the Record” and include the information they wish to share. Persons will be called upon in the order appearing on the Chat.
- Attendees were asked not to use the Chat feature to talk amongst themselves.

- 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 wish provide comments or information should email those comments to mellony.c.bernal@dhsoha.state.or.us.
- It was further noted that after the RAC process has concluded, there will 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 by email using the GovDelivery Home Health and Hospice Listservs. The link to join the listserv was shared via Chat: https://public.govdelivery.com/accounts/ORDHS/subscriber/new?qsp=ORDHS_16
- The RAC meeting will be recorded for purposes of generating written meeting notes.

The agenda was reviewed by M. Bernal.

RAC member asked whether comments should be provided on only language that is underlined or stricken. Staff responded that all rule language may be commented upon even language that is not changing.

Rulemaking Advisory Committee Overview and Scope

Overview

M. Bernal noted the following:

- State agencies convene RACs for a variety of reasons including when the legislature passes laws that require rules be adopted, when the legislature delegates broad statutory authority and the agency must interpret those laws by rule, and amending, repealing or suspending existing rules.
- RAC members include persons and communities that are most likely o be affected by the proposed rules including representation from licensed facilities, special interest groups and associations.
- The Health Facility Licensing and Certification (HFLC) program drafts the rule text and convenes the RAC to seek input and suggestions on the rule text and consider possible changes, concerns, issues, etc. 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.
- The RACs role is advisory only and consensus is not necessary. The HFLC program retains the final decision on final rule text.
- Considering information provided by the RAC, the HFLC program 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.
- The HFLC program will review and consider all of the testimony and comments received and determine whether additional changes to the rule are necessary based on those comments. The HFLC program will provide a response to the testimony and comments received.
- The HFLC program will finalize rule text and determine effective date and file permanent rulemaking notice with the Secretary of State's office.

Scope

- The purpose of this RAC is to consider proposed changes to the hospice licensing rules. The current rules were adopted in 2010 after passage of SB 161 (2009) and have not been updated since, with the exception of the fee change in 2017. Amendments proposed align with other licensed facility type rules and include standard licensing processes and procedures.
- The RAC will consider proposed amendments including possible fiscal and economic impact to hospice programs, units of local government, the public, and small businesses as well as the effect on racial equity in Oregon.
- The number of meetings will depend on how quickly the RAC can work through the amended rule text. The agency anticipates no more than 1-2 meetings.
- Staff acknowledged that while most revisions will be discussed during the meeting, additional changes may take place between meetings and members will be kept advised. It was noted that the counsel from the Department of Justice must review all of our rules which may result in changes outside the context of the RAC meeting.
- Goal is to have final proposed rules submitted to the Public Health Division's Rule's Coordinator by November 7th for posting in the December 1 Oregon Bulletin. If this time frame is met, a public hearing could be scheduled on or after December 15th and the written public comment period ending on or around December 22nd.
- Rule could potentially be effective January 1, 2023.

Administrative Rule Review

M. Bernal shared information on the structure of administrative rule numbers and began the discussion on the proposed amendments.

OAR 333-035-0115 – Compliance with Federal Law

A new rule has been added to clearly identify that a hospice program must comply with 42 CFR 418. This requirement is currently in rule but specifying the requirement under its own rule at the beginning makes it clear and identifiable. Discussion:

- RAC member suggested that the last sentence be amended to identify the applicable OAR rule range rather than refer to "these rule" since it may be misinterpreted as referring to federal CMS rules.
- RAC member via Chat concurred.

No additional comments were shared by RAC members.

ACTION: Consider amending "these rules" to OAR 333-035-0110 through 0300.

OAR 333-035-0120 – Definitions

New and amended definitions were identified. Discussion:

- RAC member asked whether the definition of '**administrator**' should include reference that the administrator is responsible for the day-to-day operations and must be a hospice employee to align with CMS Conditions of Participation (CoP). It was further noted that there has been some confusion about the administrator having to be a hospice employee. Staff noted that generally Oregon administrative rules should include definitions that are not

already specified by the CMS CoP. Staff acknowledged the difficulty of having to look in two different places for regulations.

- The definition of **'Hospice aide**' has been amended by removing the requirement that the aide be a Certified Nurse's Aide (CNA) and instead aligns with the requirements in the CMS, Conditions of Participation. The HFLC program modified this definition to address concerns raised in rural Oregon and the current on-going staffing shortages across licensed facility types.
  - RAC member noted that the use of both the terms 'nurse's aide' and 'hospice aide' is confusing and suggested that nurse's aide be removed. RAC member further asked that staff review terms for consistency. Staff noted that the term nurse's aide is reflected in statute and therefore cannot be removed. Further changes reflected for this definition are also due to changes made in statute with the exception of 'hospice aide.' The HFLC program cannot change statutory definitions but may provide additional language for clarification or context which is why hospice aide was added.
  - The representative from the Oregon State Board of Nursing suggested that subsection (7)(a) be revised to reflect 'A certified nursing assistant (CNA) certified by the Oregon State Board of Nursing under ORS 678.442.' The acronym CNA is well known and frequently utilized. It was further noted that a person trained as a CNA but who has not yet passed the exam may be hired for up to 120 days. It was further suggested that section (12) also refer to a CNA versus a nurse's aide.
  - RAC member stated that a CNA needs to be licensed when hired.
- RAC members expressed concern about the definition for **'Interdisciplinary team**'.
  - RAC member expressed concern regarding the reference to "the patient's attending physician or clinician," as part of the interdisciplinary team. It is usually the hospice physician that participates in meetings not the patient's attending physician or clinician. It was noted that every patient has the choice to include their attending physician. Discussion ensued regarding how the hospice team works with a non-hospice attending physician on providing care for the patient. Day-to-day orders and plans of care are handled by the hospice physician and the non-hospice attending physician is kept informed. It was further noted that the definition is substantially different than the definition used in the CMS CoPs.
  - RAC member noted via Chat that the CoP specifies that the 'interdisciplinary group (IDG)' must include but is not limited to individuals who are qualified and competent to practice in the following professional roles: (i) Doctor of medicine or osteopathy who is an employee or under contract with the hospice; (ii) a registered nurse; (iii) A social worker; and (iv) a pastoral or other counselor. It was suggested that maybe the definition should be removed. Staff noted that definitions used in statute must be followed regardless if restated in the rule.
  - RAC member noted that if the intent of the definition is to capture the team of persons who are ultimately coordinating care, then language should be updated to include the hospice physician.
  - RAC member noted that the term 'clinician' could mean anyone.
  - RAC member noted that not all attending physicians are trained in palliative care and noted that the Oregon statute is incongruent with federal regulations.
  - RAC member suggested that a statutory amendment be considered in the future.
  - RAC member suggested that the definition include reference that the IDG works in collaboration with the patient's attending physician or clinician.

- HFLC surveyor pointed out that the discussion has centered around the requirements of the *interdisciplinary group (IDG)* that meets on a regular basis. The *interdisciplinary team* includes the participation of patient or the patient family unit and noted that the patient or patient family unit rarely participates in the IDG meeting. The definition includes reference to the attending physician or clinician to clarify that the patient's provider is included as part of the team of persons that has input into the patient's care. It isn't necessarily the requirements of the IDG required by federal CMS CoPs. It was also noted that naturopaths have been added to the definition pursuant to statute, and these providers are not recognized by the federal CoPs.
    - RAC member asked then why make any changes to persons in the definition. Staff responded because the requirement is reflected in Oregon law. (ORS 443.850(3).)
    - RAC member via Chat expressed concern about compliance with both the interdisciplinary 'team' and interdisciplinary 'group.'
    - **FOLLOW-UP – After further review of the definition, it does reference "*hospice program personnel*" including 'the physician.'**
- RAC member inquired whether the reference to 60 miles in the definition for '**parent hospice program**' is in statute? Staff responded that the language is in rule not statute, and that waivers have been available to ensure service is available in some areas where there might not otherwise be a provider.
    - RAC member responded that they thought it was only in the home health rules and not hospice. Staff noted that the 60-mile requirement is noted in OAR 333-035-0055(6) and 0055(11).
    - RAC member suggested that the language be revised to specify "60-mile radius."
    - Several RAC members via Chat concurred with '60-mile radius' suggested change.
    - RAC member asked whether the 60-mile requirement applied only at time of licensure. Staff responded that the 60-mile service area has been a requirement and that the language has been added for clarity.
- RAC member asked if the proposed definition for 'palliative care' meets the definition for "nurse practitioner run palliative care programs in existence." Staff noted that these proposed rules are specific to hospice programs and does not apply to other facilities or programs that offer palliative care services. Concern was expressed that the definition may 'lock organizations into a type of palliative care.' The definition of palliative care under ORS 413.273 was placed into the Chat for reference.
    - (1)(d)(A) “Palliative care” means patient-centered and family-centered medical care that optimizes a patient’s quality of life by anticipating, preventing and treating the suffering caused by serious illness and involves addressing the patient’s physical, social and spiritual needs and facilitating the patient’s autonomy, access to information and choice. (B)“Palliative care” includes, but is not limited to, (i) Discussing a patient’s goals for treatment; (ii) Discussing the treatment options that are appropriate for the patient; and (iii) Comprehensive pain and symptom management.

ACTION: Consider the following changes – 1) adding reference to an administrator having responsibility for day-to-day operations and having to be an employee of the hospice program; 2) Modify subsection (7)(a) and section (12) to reflect CNA; 3) Consider changing the interdisciplinary team definition to include specific reference to the hospice physician and collaboration with the attending physician; and 4) Consider changing the reference to 60-miles in the definition of parent hospice program to '60-mile radius'.

OAR 333-035-0125 – Application for Licensure and Fees

Staff provided a summary of the changes made in sections (2) through (9). Discussion:

- RAC member questioned whether new section (2) requiring documentation of policies and procedures, documentation that patient care and systems have been developed and documentation of sufficient qualified staff prior to licensure may disadvantage small businesses and could it be an equity concern when a community is trying to come together and form a hospice. The requirements would be easy for a large business expanding operations and difficult for smaller businesses. Staff responded that this requirement is already in place and is part of the application for license where the administrator/owner must attest to requirements being in place. It is being added to rule to have a citing mechanism when an administrator/owner has attested to the requirements but at time of survey the hospice program is not in compliance. The purpose of this language is to ensure that when a hospice program is issued a license that they are ready to provide services to patients and have the necessary staff in place to provide those services.
- RAC member expressed concern about subsection (5)(a) requiring application for a new license if a hospice program moves 30 miles from its current physical location. It was noted that the number of miles is too low, especially for rural programs. Staff responded that the intent of this rule was to 1) clarify current service area requirements, and 2) capture a move that would require new staff and other changes. RAC member suggested changing to 40 miles.
  - RAC member asked what the concern is when a hospice program moves anywhere within its service area (60 miles).
    - Staff responded that staffing is the primary concern – a hospice program must be able to have adequate staff to provide services to its population.
    - Staff noted that any move within the existing service area changes the entire radius of the service area.
    - RAC member stated that currently only the branch must be within 60 miles and the proposed rules have added reference to the patient being within 60 miles. The RAC member asked whether the rules have a waiver requirement. It was noted under current rule OAR 333-035-0055(7), the Division may waive the mileage guidelines in section (6) if the parent hospice program proposes to provide services to an underserved area and can adequately demonstrate the ability to provide services in the underserved area.
    - Discussion ensued regarding the applicability of the 60-mile requirement based on current rule language, how the Authority is currently applying the service area requirement, and the Authority's intent to make it clear in the proposed new rules how the service area is being applied. RAC member suggested that the proposed 60-mile service area only applies to home health agencies and not hospice programs. RAC member further stated there is nothing in regulations that limit a hospice "branch" to serve patients only in a 60-mile radius. If there is a second branch, then a 60- mile service area requirement would apply and the waiver requirement only applies to opening a second site. Staff disagreed.
  - RAC member comments via Chat included:
    - This (service area) is not a new requirement;
    - Suggestion that text be revised to "moving outside of current service area;"

    - Agreement about the confusion of the 60-mile rule for a service area for hospices located in Oregon. Current rules reference out-of-state hospices who also serve patients in Oregon and how far into Oregon they could come.
    - Current hospice rules do not appear to define limits of a service area similar to home health agencies.
  - Staff asked RAC members to submit additional concerns in writing via email.
- RAC member commented on section (5), specifically with regard to change of ownership where larger systems are acquiring multiple hospice programs. These ownership changes may result in drastic policy changes that may impact equity in Oregon and the state needs to consider that potential equity impact before the ownership actually changes. Staff noted that a change of ownership does not necessarily require submission of new policy documentation that is required under paragraph (2)(b)(A). Staff noted that under new legislation specific mergers and acquisitions are subject to approval.
  - RAC member commented that in state of Washington there is a right to die and certificate of need administrative process where the public can comment before granting a license. Concern was noted that persons should not be prevented from making their own choices relating to their care. Staff stated that Oregon does have a certificate of need law, but it does not apply to hospice programs unless the hospice is applying for licensure as a Special Inpatient Care Facility. Staff further noted recent legislation regarding mergers and acquisitions and will look into further.
  - **FOLLOW-UP: The Health Care Market Oversight (HCMO) program was established within the Oregon Health Authority, Health Policy and Analytics Division, Office of Health Policy to oversee health care consolidation. HB 2362 (2021) directs the Oregon Health Authority (OHA) to review business deals involving health care entities, such as hospitals, health insurance companies, and provider groups. One of the aims of this program is to support statewide priorities including ensuring that health care consolidation in Oregon supports statewide goals related to health equity, lower costs, increase access, and better quality. Transactions subject to review, as well as requirements for review, are found under OAR chapter 409, division 070. The recent acquisition of two Oregon hospice programs by Falcon Hospice GP, LLC was subject to HCMO review and information can be found at: https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-transaction-notices-and-reviews.aspx**
- Via Chat and orally, RAC member asked for purposes of section (5), what does organizational structure mean? Does it apply to restructuring of staff? Staff responded that it does not apply to operational issues, rather the focus is on elements of the specific license application. It was requested that additional details or a definition be considered.
- RAC member stated via Chat acknowledgement that it was great to see information in the rule [section (6)] acknowledging that an in-home care agency license is not needed for a hospice program to provide palliative care.
- RAC member suggested revising subsection (7)(c) to state, "*A hospice program licensed in* a bordering state must comply with the geographic service area restrictions…"

ACTION: Staff will consider the following: 1) applicability of the service area requirements including number of miles moved that would require a new license; 2)

amending subsection (7)(c) to include reference to 'a hospice program licensed in a bordering state…'; and 3) providing a definition or additional details for meaning of "organizational structure."

OAR 333-035-0130 – Review of License Application

Staff noted that this is a new rule to align with other facility licensing rules and outlines what the Authority does in reviewing a license application. Discussion:

- RAC member expressed concern regarding section (4) if a hospice program would be prevented from providing services if the program had obtained CMS certification but was still waiting for a license survey from the state. Staff responded that the state licensure survey must happen before a CMS survey that would grant certification. State licensure is a prerequisite to obtaining CMS certification.
- RAC members had no additional comments.

ACTION: None

OAR 333-035-0135 – Approval of License Application

This rule aligns with other facility licensing laws and staff briefly summarized each section. Discussion:

- RAC member recommended under section (2) to add language that would be congruent with decisions made about mileage requirements and moving locations. For example, 'A hospice program that wishes to relocate its services *more than 30 miles away,* must apply for a new license.'
- RAC member via Chat concurred with suggested revision.
- RAC member via Chat asserted, "The 60-mile radius has not been an OAR for hospices and would add an unintended consequence to patients being served by a hospice.

ACTION: Revise section (2) by adding mileage requirement after consideration of previous service area discussion.

OAR 333-035-0140 – Denial of and License Application

This rule aligns with other facility licensing laws and staff noted that the agency must comply with ORS chapter 183, the Administrative Procedures Act (APA) when taking a licensing action. Discussion:

- RAC members had no comments.

ACTION: None

OAR 333-035-0145 – Expiration and Renewal of License

This rule aligns with other facility licensing laws and information in this rule was moved from other areas. Staff summarized rule sections. Discussion:

- RAC members had no comments**.**

ACTION: None

OAR 333-035-0150 – Denial, Suspension, or Renewal of License

This rule aligns with other facility licensing laws and clarifies that any licensing action taken shall be in accordance with the APA. Discussion:

- RAC members had no comments.

ACTION: None

OAR 333-035-0155 – Return of License and Hospice Program Closure

Staff provided a summary of the proposed rule text which aligns with other facility licensing laws.
Discussion:

- RAC member inquired about section (3) relating to retention of records and suggested that pediatric patient records should be retained for seven years after the patient reaches 18 years of age. Staff replied that other facility licensing rules have different requirements for pediatric records and will look into further.
- RAC member concurred that pediatric records should be kept longer and questioned whether some other records needed to be kept ten years.
- RAC member via Chat concurred with pediatric record retention comment.
- RAC member asked if there are specific record retention requirements for health care organizations under OAR why must there be a separate retention for hospice programs who are health care organizations or just reference the applicable OAR. Staff responded that it's HCRQI's practice to have this information by specific facility type including custody of records after closure.
- RAC member via Chat agreed with comment above.

ACTION: Staff will consider additional retention language for pediatric records and will research other OARs that may have similar retention requirements.

OAR 333-035-0160 – Geographic Service Area

Staff noted that this is the rule that further describes and defines requirements around the geographic service. Staff further noted that unless RAC members have additional comments, the comments received previously will be considered further for possible changes in this rule.

- RAC member via Chat stated that it would be nice if under section (4), "underserved area" and "adequately demonstrates ability to manage and control the services" were further defined or references provided. RAC member followed up stating that any type of criteria to help define underserved area would be helpful, for example a hospice utilization rate of 10% below state average.
- RAC member stated that there are some areas of the state with one or fewer hospice programs serving these area with long wait lists. RAC member questioned why wouldn't we want a hospice program to serve these areas that are outside the 60-mile radius service area? Staff responded that waivers have been allowed for these situations if the hospice program has the capacity to do so. RAC member indicated that with the confusion around service area and waivers, underserved area should be defined.

ACTION: Staff will consider comments regarding the 60-mile radius service area shared previously and will consider defining underserved area.

OAR 333-035-0170 – Advance Directives

Staff noted that under CMS CoPs, hospice program are required to inform and provide information regarding advance directives [(42 CFR 418.52(a)(2)]. This rule specifies the Oregon state requirements relating to policies that health care organizations must have in place, material that must be distributed and timing of distribution of material. These laws are promulgated under ORS 127.649 and ORS 127.652 and apply to hospitals, long term care

facilities, home health agencies, hospice programs and health maintenance organizations. Discussion:

- RAC member asked if a patient has completed a POLST, could the hospice program offer an Advanced Directive versus providing a copy. It was noted the form and booklet are very expensive to reproduce and if a patient may be imminently dying and has a POLST, it would be an unnecessary burden and unnecessary waste. Staff will review law further but noted that the POLST and Advance Directive are two different documents.
- RAC member agreed that the POLST form, and Advance Directive forms are two completely different legal documents, serving different purposes and both must be obtained.
- Additional RAC members concurred with statements above.
- RAC member questioned use of term "or" under subsection (2)(a) with respect to appointing a health care representative and recommended changing to "and." Under section (4), RAC member stated that an earlier time frame should be considered for giving a person an opportunity to complete an Advance Directive as some people may die before the 15-day requirement. Staff responded that the 15-day requirement is in Oregon statute but will consider the request further. Staff also noted that for purposes of administrative rules the term "or" is equivalent to 'and/or' whereas "and" means both must occur.
- RAC member inquired whether instead of the 'name of person' under subsection (2)(d) change to, or add, the title of a position given staff turn-over. Staff noted that ORS 127.649 specifies 'name of person.'
- RAC member inquired about the need to provide written policies based on language under subsection (2)(b). Staff responded that ORS 127.649(1)(a)(B) specifies that a health care organization must maintain written policies and procedures that provide for delivering to the patient *information* on the policies of the organization with respect to implementing the rights of an individual to make health care decisions.' Another RAC member stated via Chat, 'Isn't this the bill of rights?' Other RAC members concurred.
- RAC member inquired about the language in section (4) that specifies that written information must be provided not later than 15 days after initial provision of care, but in any event *before discharge of the patient.* It was noted that some patient may die within minutes of a nurse entering the door and would therefore not comply with this rule. It was recommended that the language be changed to 'live discharge.' Staff noted that ORS 127.652(3), specifies a hospice program shall provide written information before '*ceasing to provide care.'* RAC member noted that even at death the hospice program does not cease to provide care, care is provided to the family after death. It wouldn't make sense to be talking about Advance Directives of deceased patients with the bereaved.
- RAC member concurred via Chat with recommendation of 'live discharge' and the confusion around current language.

ACTION: Staff to consider further: 1) the 15-day time frame for providing Advance Directive information and whether it should be earlier; 2) updating section (4) to providing information prior to *live discharge of the patient*.

OAR 333-035-0175 – Health Care Interpreter Services

Staff noted that this rule is being added as a result of HB 2359 that passed during the 2021 legislative session (2021 Oregon Laws, Chapter 453.) Providers as defined in the bill must work with health care interpreters that are registered on the OHA, Health Care Interpreter registry and the OHA is responsible for enforcement with respect to facility compliance. Discussion:

- RAC member expressed confusion given recent administrative rules promulgated under OAR chapter 333, division 002 and questioned whether additional rule references needed to be added to hospice rules. Staff responded that the health care interpreter administrative rules are managed by the Office of Equity and Inclusion and that requirements for persons being eligible for the registry and placed in the registry would not need to be included in this rule set.
- RAC member via Chat noted that the registry is only for five languages and is for individuals. RAC member questioned whether the vendor providing the service would verify that the interpreter is registered. It was noted that a hospice program is not going to have the time to try and ensure an interpreter is on the registry when a patient is actively dying. Staff noted that a hospice program could work with the hospital's interpreter since all health care facilities are required to comply with the law. RAC member responded that the hospice program would be required to use their contracted provider. Staff responded that for purposes of enforcement, a hospice program would need to ensure that any contract that they have with interpreter vendors must ensure that interpreters used are registered with the OHA health care interpreter registry or that exceptions to the requirement are well documented (reference OAR 333-002-0250). It was noted that there are requirements under OAR 333-002-0250 that require documentation of interpreter encounters. It is up to the facility on how and where to document those encounters (e.g., patient medical record or separate list of specific interpreter encounters.) RAC member stated this will be a significant administrative burden.
- RAC member noted that the registry has seven certified languages (Arabic, Cantonese, Korean, Mandarin, Russian, Spanish, and Vietnamese). Staff responded while there are only seven certified languages, the registry lists qualified health care interpreters for numerous other languages.

ACTION: None

OAR 333-035-0180 – Clinical Records

Staff summarized provisions of new rule. Discussion:

- RAC member recommended that the last sentence in section (1) include reference to maintaining the records in accordance with the record retention requirements specified in OAR 333-035-0155.

ACTION: Staff will consider adding reference to OAR 333-035-0155(3) to section (1).

OAR 333-035-0190 – Infection Control

Staff provided a summary of the rule elements. Discussion:

- RAC member inquired whether these requirements are identified in other regulations so that it is not necessary to repeat in hospice rules. Staff noted that this rule includes additional elements not otherwise covered by the CMS CoPs (42 CFR 418.60). RAC member then asked whether that means a hospice program is a higher risk organization than other health care facilities for infection prevention. Staff responded no and noted that similar rule text has been adopted in many of the facility rules. It was also noted that the language around standard precautions and personal protective equipment (PPE) is a direct result of the COVID-19 pandemic.

ACTION: None

OAR 333-035-0200 – Quality Assessment and Performance Improvement

Staff provided a summary of the rule elements and noted that the quarterly reporting requirement is more prescriptive than current CMS CoPs. Discussion:

- RAC members had no further comments.

ACTION: None

OAR 333-035-0210 – Criminal Records Check

Staff noted that for the most part the rule remains the same. Definitions have been added for clarity including a definition for disqualifying condition, subject individual, and fitness determination. Staff summarized definitions and additional housekeeping changes made for better clarity. Staff noted that the rule still provides that if a subject individual is licensed by a health professional regulatory board, then a background check is not required. It does not prevent a hospice program from running a background check on these individuals if they choose to. Staff further noted that since the rules are aligning with CMS CoPs for definition of a hospice aide and not requiring a hospice aide to be a CNA, a hospice program would need to complete a background check. Staff further noted that if a hospice program has a contract with OHA's Medicaid Program, background checks would need to be conducted through the OHA/ODHS Background Check Unit.

- RAC member inquired whether the 10-day requirement that a subject individual must disclose a criminal conviction; arrest, indictment, or charge for a sexual offense or property crime; or any disciplinary action taken by a licensing board under section (7) is in statute. Staff responded it is not in statute. RAC member asked other hospice programs to comment if the time period seems too long.
- RAC member noted that contracted staff can be persons under various disciplines and many background checks are conducted by the agency the hospice program contracts with. It was suggested that additional language be added, 1) clarifying that a hospice program can rely on the background checks conducted by the contracted agencies, and 2) that documentation that a person has passed a background check can be maintained by the contracted agency and requested by the hospice program for verification if needed.
- RAC member concurred with comments above and questioned whether individuals working for a call center or other individuals with access to personal information would need a background check. Staff responded yes. RAC member indicated it would be a burden for hospice programs to have to retain background check documentation for individuals where the contracting agency has conducted the background check (e.g., call center staff who answer calls after hours.)
- RAC member raised question whether the rules mean that a hospice program is not allowed to decide on whether an individual can work for a hospice program who may have a personal history of drug or alcohol dependency. This does not mean they are unsuitable for a position. Additionally, section (4) reference to "reasonably raises questions" is unclear. Staff responded that the intent is that the hospice program is responsible for having policies and procedures in place that identify who may be disqualified or what conditions a program may determine that someone may not be employed. RAC member asked that language be clearer and consider adding the language "if found unfit."
- RAC member via Chat concurred with concerns noted above on section (4).

ACTION: Staff will review background check language and consider revising to 1) Make it clear that the hospice program is responsible for determining fitness based on policies and procedures; and 2) make it clear that a hospice program can rely on the criminal background checks conducted by contracted vendors.
OAR 333-035-0220 – Complaints
Staff provided a summary of the rule elements and noted that the quarterly reporting requirement is more prescriptive than current CMS CoPs. Discussion: • RAC members had no further comments.
ACTION: None
OAR 333-035-0230 – Investigations
Staff provided a summary of the rule elements and noted that changes align with other licensed facility types. Discussion: • RAC member had no further comments.
ACTION: None
OAR 333-035-0240 – Surveys
Staff opened discussion on comments related to proposed survey rule language. • RAC member noted that the rule prescribes a survey be conducted prior to licensure and every three years thereafter under section (1). It was noted that hospice programs experience a lot of angst when surveys are delayed. It was requested that language be added that if the state agency is late in conducting the survey, that the hospice program would not face consequences. Staff responded that the survey requirement is the responsibility of the OHA, and no hospice has faced consequences due to the state conducting a late survey. Staff acknowledged that due to COVID, CMS halted surveys for approximately seven months and there is a backlog for recertification and re-licensure. Neither CMS nor the OHA will take an adverse action based on the delay of the state in conducting surveys.
ACTION: None

Next Steps
Staff thanked RAC members for their comments and feedback. M. Bernal will send by email a new meeting poll to schedule one additional meeting. RAC members were asked to submit any specific language changes to rule text to M. Bernal by email.

Meeting adjourned at 3:55 p.m.