DATE: January 28, 2026

TO: Hearing Attendees and Commenters –
Oregon Administrative Rules chapter 333, divisions 27, 35, 71, 500, 505, 535 – "Workplace Violence Prevention Safety Requirements in Healthcare Settings and Administrative Updates"

FROM: Brittany Hall, Hearing Officer and Administrative Rules Coordinator

cc: Dana Selover, Section Manager
Health Care Regulation and Quality Improvement

SUBJECT: Presiding Hearing Officer's Report on Rulemaking Hearing and Public Comment Period

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Hearing Officer Report

Date of Hearing: December 16, 2025, via Microsoft Teams

Purpose of Hearing: The purpose of this hearing was to receive testimony regarding the Oregon Health Authority (OHA), Public Health Division, Health Care Regulation and Quality Improvement section's proposed permanent amendments and repeal of Oregon Administrative Rules in chapter 333, divisions 027, 035, 071, 500, 505 and 535 in response to the passage of SB 537 (2025 OL ch. 535, §9, 12-13). This legislation requires specific health care settings to implement policies and procedures relating to workplace violence prevention safety requirements including identifying and assessing possible health and safety-related risks that staff may encounter, provide workplace training, conduct safety assessments, implement client identification processes, create safety check-in processes, and implement the use of visual flagging and electronic health record flagging for purposes of identifying persons who may pose a potential threat or who have disruptive behavior.

Additional changes include removing outdated language and allowing greater flexibility for a home health agency to serve a larger service area when serving a historically underserved population. Also, in alignment with hospital rules, proposed changes require a home health agency, hospice program or special inpatient care facility (SICF) to conduct an equity analysis of populations that may be impacted by a request to waive an administrative rule and provide steps to mitigate possible impacts to disproportionately affected populations. Due to passage of SB 965 (2023 Oregon Laws, ch. 199), confidentiality provisions were added for filing a complaint about a hospice program, and procedures clarified for employees reporting possible violations of rules.

Hearing Officer: Brittany Hall

Testimony Received: Two individuals provided testimony at the hearing.

Other Comments: Ten individuals or organizations submitted written comments during the rule advisory committee (RAC) process. Written comments received during the RAC process are attached to this report as **EXHIBIT 1.** Three individuals or organizations submitted written comments to OHA within the period allotted for public comment, which closed at 5:00 PM on December 22, 2025. Written comments received during the public comment period are attached to this report as **EXHIBIT 2.**

In written comments received during the rule advisory committee (RAC) process, OHA received a request to add a definition of “hazards” to the rule text, as opposed to spelling hazards out in detail in the body of the rule.

Agency response: In response to written feedback and discussions at RAC meetings, the OHA added a definition for the term "hazards" to the administrative rules, which was included in the Notice of Proposed Rulemaking attached as **EXHIBIT 3**. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

In written comments received during the RAC process, OHA received comments specific to instances of the wording "Education and training for authorized staff on:" used in the draft proposed rule text reviewed by the RAC. Written comments express concern that "mandated training may represent an undue burden on healthcare workers" and "any new mandated training represents additional work on top of other administrative and clinical responsibilities without additional compensation or protected time." Written comments also note that statute does not mandate a training component. Written comments recommend that language around training use "'make available' or similar language," rather than requiring mandated training.

Agency response: In response to the written feedback, the OHA revised its administrative rules eliminating the mandate that employees must participate in safety training. Under the amended rules, facilities will be responsible for notifying personnel about the availability of safety training and for keeping documentation in each personnel record verifying that this notification was provided. This language was included in the Notice of Proposed Rulemaking attached as **EXHIBIT 3**.

In written comments received during the RAC process, OHA received a request to "explicitly define 'high-risk home visit' and require pre-visit screening, documentation, and employer-mandated mitigation." Written comments point to national guidance that "identifies predictable, recurring hazards for clinicians performing home visits," and opine that "a practical, operational definition (any one objective criterion triggers high-risk classification) will ensure consistent application across employers, enable timely protective measures (two-person visits, security escort, telehealth substitution), and create robust data for the consolidated incident reporting the statute requires."

Agency response: In response to written feedback, discussions during RAC meetings, and the statutory language in SB 537, the OHA incorporated the aforementioned definition for "hazards," rather than adding the additional terms noted above. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process note that the National Institute for Occupational Safety and Health (NIOSH) training referenced in the draft proposed rule text reviewed by the RAC "is over 10 years old." Written comments also question whether the annual training on worker safety cited in the rule text is in "addition to the required annual training in statute already i.e. SB 537 4(a) which includes a list of very specific WPV [workplace violence] training requirements for covered entities?" Comments ask, "should there be a statement that these training requirements are in addition to the requirements already stated in ORS 654.414 (SB 5374(a))?"

Agency response: In response to written feedback, discussions during RAC meetings, and information provided by legislative staff regarding intent, the OHA interprets the legislation to permit facilities to use training that *is consistent with* models recognized by NIOSH or OSHA, rather than requiring the use of specific training materials posted on those agencies' websites. This allows facilities the flexibility to adjust training to include more up-to-date information if necessary. To further clarify the distinct training requirements established under ORS chapter 654 and Section 13 of SB 537, the OHA amended its administrative rules to state that the training requirements may be integrated into the training mandated under ORS 654.414. This language was included in the Notice of Proposed Rulemaking attached as **EXHIBIT 3**. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process request clarification of what is meant by a "safety assessment" under the requirement for agencies to conduct quarterly safety assessments with staff who have been assigned to provide home health care/hospice services. Clarification is also requested as to what "safety assessment" means in the context of special inpatient care facilities and the requirement that a freestanding hospice facility must conduct quarterly safety assessments with staff who have been assigned to provide hospice services. Written comments note that "the type of assessment in an inpatient facility would be somewhat different to those that can be conducted in a home care situation."

Agency response: In response to written feedback and discussions during RAC meetings, the OHA amended its administrative rules to clarify that the quarterly

safety assessment may use the same criteria required under ORS 654.414. This language was included in the Notice of Proposed Rulemaking attached as **EXHIBIT 3**. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process request that the rules address when home care and hospice workers need a way to call for help (for instance, when cellular phone services don't work) and for employers to know where those staff members are if they don't check in at the end of their shift.

Agency response: In response to written feedback and discussions during RAC meetings, the OHA clarified the requirements for conducting safety checks including language from ORS 654.421 and incorporated the definition of "safety check" into the administrative rules. Licensed providers must provide a mechanism that enables personnel to complete these checks, including but not limited to communication devices capable of one-way or two-way messaging, or through regular check-ins. This language was included in the Notice of Proposed Rulemaking attached as **EXHIBIT 3**. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process note that the same language regarding "safety checks" and the requirement to provide a mechanism by which staff can perform safety checks, including through use of a mobile application to access relevant safety related information, is used under both the home health and hospice rules, as well as the special inpatient care facility (SICF) rules for freestanding hospice facilities. Comments ask whether this language was needed for a freestanding facility "where there should be easy access to a patient's chart?".

Agency response: During RAC meeting discussions, the OHA clarified that an SICF classified as a Freestanding Hospice Facility provides services to inpatients and provide outpatient services under a Hospice license. The SICF license type includes other, non-hospice providers like rehabilitation hospitals. When these

other types of SICFs are licensed, they may provide outpatient services under the SICF license. As such, the administrative rules for SICFs must include the workplace violence requirements that would apply to those outpatient settings. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process note that the suggestions for visual flagging "are relevant and commonly used in an inpatient facility," but question "if these examples are relevant to home health and hospice." An example given is that "signage is not appropriate for a home setting," and comments note that colored arm bands may not be either. Written comments also request that language about visual flags be written so that the visual flags used are not stigmatizing.

Additional comments received during the public comment period note that OAR 333-035-0167(2) specifically requires hospice providers to utilize visual flags in addition to identifying potential threats or violent behavior in the EHR. Comments opine that "it would be challenging to operationalize the physical flag in a 'respectful, and non-stigmatizing manner' as required by rule," for the signage and color-coded bracelet requirements noted above. Comments recommend the removal of the physical flag requirement, or "making an exception for home-based hospice and specifying in rule that an EHR flag review must be conducted prior to hospice program staff entering a patient's home."

Agency response: As written, SB 537 **requires** a home health agency and hospice program to implement flagging systems using electronic health records flags AND visual flags (Section 9, subsections 2 and 3). As such, the OHA is unable to make an exception from visual flagging requirements. The definition of 'visual flags' does not require the use of wristbands, signage on doors or walls, or other conspicuous flags. These agencies may consider other discreet visual flagging alternatives such as a small colored dot on the visit schedule, a color-coded magnet or sticker on internal assignment boards, a note in a paper file that is assessed prior to a home visit, etc.

The OHA has amended administrative rules in response to written feedback and discussions during RAC meetings adding language that clarifies, when a visual flag

is used, it must communicate essential information in a clear, respectful, and non-stigmatizing manner to promote safety and provide neutral alerts or reminders.

Furthermore, the OHA directs persons to written comments from Rep. Nelson, a chief co-sponsor of SB 537, attached in **EXHIBIT 1**. His comments emphasize that the legislation is intended to protect both patients and health care workers, recognizing that unsafe care environments compromise not only employee safety, but also patient care, workforce retention, and patient outcomes. He also notes that visual flagging under SB 537 is meant to support situational awareness, not to label or penalize patients, and discreet visual cues can prevent avoidable safety incidents. Prohibiting all physical or visual flagging in community-based care settings would conflict with SB 537's core goal of ensuring people receive the support needed to keep everyone safe.

Written comments received during the RAC process opine that the following rule language in the draft proposed rule text reviewed by the RAC is "subjective and up to interpretation by the patient and/or their family." Comments request that this language be further clarified.

(4) Providers and staff of an agency may not take any of the following actions based solely on the presence of an EHR flag:
(g) Punish or penalize the patient.

Agency response: Based on discussions with the RAC and language in SB 537, the OHA believes that no further clarification is needed. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process question whether the following language in the draft proposed text reviewed by the RAC applies to a freestanding facility:

333-071-0423
Worker Safety Program Requirements
(1) Patient intake risk assessment...
(a) Presence of pet(s) and if any, whether the pet(s) can be secured away from the area where care is provided, if requested by staff;

(b) Possible pest infestations, for example, rodents or insects; and
(c) Presence of weapons and if any, whether the patient is willing to securely store them before a staff visit.

Agency response: As indicated previously, an SICF classified as a Freestanding Hospice Facility provides services to inpatients and provide outpatient services under a Hospice license. The SICF license type includes other, non-hospice providers like rehabilitation hospitals. When these other types of SICFs are licensed, they may provide outpatient services under the SICF license. As such, the administrative rules for SICFs must also include the workplace violence requirements that would apply to those settings. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process note that the only time "rehabilitation hospital" is mentioned in the draft proposed rule text reviewed by the RAC is under OAR 333-071-0425(3). Comments ask "shouldn't all WPV [workplace violence] related rules for freestanding hospice facility [*sic*] apply to a SICF classified as a rehabilitation hospital?".

Agency response: Under ORS 442.015(15)(b), a hospital is defined to include an SICF as that term is defined by OHA in rule. OAR 333-071-0205 defines an SICF as a facility with inpatient beds that are designed and utilized for special health care purposes, including but not limited to a rehabilitation hospital, substance use disorder treatment facility, freestanding hospice facility, or a religious institution. SB 537, sections 12 and 13, only apply to home health agencies and hospice programs, and would not apply to rehabilitation hospitals. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process request that "any proposed rules related to SB 537 – such as the written language and SOGI [sexual orientation and gender identity] changes in OAR 333-505-0036 – be considered separately as they extend beyond the scope of this legislation."

Agency response: As discussed during the initial RAC meeting, the OHA often streamlines administrative rulemaking by incorporating minor or housekeeping changes when appropriate, even if the RAC is convened for a specific purpose. In this case, minor revisions were made to OAR 333-505-0036 to align the terminology used in the Oregon Crisis Care Guidance with the language in the administrative rule. This language was included in the Notice of Proposed Rulemaking attached as **EXHIBIT 3**. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments regarding OAR 333-027-0125, Potential Threat or Disruptive Behavior Flagging Systems, received during the RAC process, opine that "while visual indicators may be suitable in facility-based environments where they can be consistently monitored, they are impractical in home health or hospice settings. Requiring patients to display such indicators on private residences may be stigmatizing and unreliable." Written comments recommend that visual flags for home health settings be removed and "instead rely solely on EHR [electronic health record]-based flagging systems to ensure effective and equitable implementation."

Agency response: Please see previous response about this topic on pages 6 and 7.

Written comments received during the RAC process note that the draft proposed rules reviewed by the RAC "prohibits providers and staff from contacting, reporting or disclosing information to law enforcement based on the presence of an EHR flag." Comments opine that "the rule lacks clarity regarding the circumstances under which agencies may contact or disclose information to law enforcement." Written comments request "clarification on permissible circumstances for law enforcement contact to ensure appropriate implementation."

Agency response: In response to written comments and discussions with the RAC, the OHA amended administrative rules providing additional context and clarifying that a provider and staff of a facility may not contact, report or disclose

information to law enforcement solely on the presence of an electronic health record flag unless it is necessary to prevent or lessen serious or imminent threat to employee, patient, caregiver or others' health or safety. This language was included in the Notice of Proposed Rulemaking attached as **EXHIBIT 3**. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process request that proposed OAR 333-500-0025(h), regarding satellite facilities, be amended to require electronic health record (EHR) flagging, with optional use of visual flags where applicable. The rationale given for this request is that "requiring both visual and EHR flagging systems in satellite facilities may be overly burdensome and impractical, particularly in fast-paced clinic environments where patients may only be present briefly. Visual cues in such settings are unlikely to prevent incidents effectively."

Further written comments regarding satellite locations request that the same requirements apply to satellite locations as they do for hospitals, to "ensure that these environments are safe for both health care workers and patients to be able to receive the care they need."

Agency response: A satellite location that operates under a hospital's license is subject to hospital standards, including these rules. As written, SB 537 **requires** a hospital to implement flagging systems using electronic health records flags AND visual flags (Section 9, subsections 2 and 3). As such, the OHA is unable to make an exception from visual flagging requirements. The definition of 'visual flags' does not require the use of wristbands, signage on doors or walls, or other conspicuous flags. A hospital may consider other discreet visual flagging alternatives such as a small colored dot on the visit schedule, a color-coded magnet or sticker on internal assignment boards, a note in a paper file that is assessed prior to a home visit, etc. Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process request a revision to the draft proposed rules reviewed by the RAC related to Potential Threat or Disruptive

Behavior Flagging Systems (OAR 333-035-0167, 333-071-0425, 333-505-0045). Written comments opine that "flagging at initiation is the most critical time to flag. Requiring separate clinical documentation in the patient's EHR for continuation, inactivation and reactivation is not related to patient care and is an administrative burden." Comments request that the requirement be revised to "allow for supporting clinical documentation, rather than a linked note, ensuring alignment with ADA standards and minimizing administrative burden," and that flagging at continuation, inactivation or reactivation be removed.

Additional written comments agree that the "requirement for a 'linked clinical note' is an unnecessary and unrealistic burden," also recommending that it be removed, and recommending that the rule text be revised to remove flagging at continuation or inactivation, leaving in flagging at reactivation.

Additional written comments suggested that electronic health record systems do not allow for a direct electronic link, and developers of those systems may not be able to add a plain text field. It was further noted that a person's behavior may be exhibited prior to triage and therefore may be outside a health care provider's ability to chart the behavior. Comments request that the requirement be changed to, "Whenever possible, a reference to progress note from the chart will be added to the flag entry."

Also related to flagging systems, written comments note that section (4) of the above listed rules "includes a list applicable to both virtual and EHR flagging systems but only indicates that they are related to an EHR flagging system." Comments recommend that the rule text be amended to add that the section also applies to visual flags.

Agency response: In response to written comments, discussions during RAC meetings, and the legislative language of SB 537, the OHA modified its administrative rules removing reference to a linked 'clinical note' and clarifying that an electronic health record (EHR) flagging systems must support that a flag-related action was taken, including initiating or reactivating a flag. This rule language was included in the Notice of Proposed Rulemaking attached as **EXHIBIT 3.**

In response to the request to amend the rules to state that providers and agency staff may not take certain actions based solely on the presence of an EHR or visual

flag, the OHA declined to make this change because it is not supported by SB 537. Section 9, subsection (4) states: *Providers and staff of a covered entity may not take any of the following actions based solely on the presence of an electronic health record flag:..."*

Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process regarding "inclusive flagging language" (OAR 333-035-0167, 333-071-0425, 333-505-0045) in the draft proposed rules reviewed by the RAC, recommend expanding the flagging criteria to include "patient, caregiver, or support person." Suggested language provided:
(3)(a)(M) Establishing a process by which a patient, caregiver, or a person authorized to make health care decisions on behalf of the patient, may request review and removal of an EHR flag.

Agency response: In response to written comments and discussions during RAC meetings, the OHA modified its administrative rules to include reference to caregivers and support persons. This rule language was included in the Notice of Proposed Rulemaking attached as **EXHIBIT 3.** Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process state that the rules are written as a "one-size fits-all" approach that "*requires* all hospitals, all home health agencies and all home hospice programs to adopt a health record flag system, whether the agency needs it or not." Written comments opine that "agencies and hospitals should not be *forced* to adopt" a health record flag system that may not have demonstrable applicability to the services they provide.

Written comments also note the "systemic racial disparities in how the flags apply, with Black patients being flagged twice as often as white patients", and subsequently having longer waits, less treatment, and worse care. Written comments further opine that "any benefit of these flagging systems also do not justify the problems they create."

Written comments opine that "the proposal for visual flags is frustratingly vague as it relates to home health agencies" and "the justification for such a visual flag in home health care is hard to understand." Comments note that an "agency has no right to require a person to post a visual flag on the premises of their own home or to require a person to wear a stigmatizing bracelet, badge, or other item in the privacy of their own home." Comments further note that "in the context of home health care and home hospice care, routine scheduled providers will know for days or hours in advance which home care patients they will see and have ample time to familiarize themselves with a medical record, including any such flags."

Written comments related to flagging also note that while the proposed rules have many protocols and require many steps, they contain "little detail for getting an innocent or rehabilitated patient *off* the list of flagged patients." Comments further note that while the rules require an affected agency or hospital to "establish a process by which a patient, or a person authorized to make health care decisions, may request review and removal of an EHR flag," "the proposed rule imposes no limitation on any such policy, just that it exist."

Agency response: In response to written comments and discussions during RAC meetings, please reference the response on pages 6 and 7 of this report regarding the statutory requirement for flagging in home health agencies and hospice programs. Additionally, the OHA revised its administrative rules to require that electronic health record flags be reviewed at least every 12 months to determine whether the flag should be maintained or removed. The OHA believes that facilities should retain the flexibility to establish a review and removal process that aligns with their operational needs and business model, including when persons may request the review and removal of a flag. This rule language was included in the Notice of Proposed Rulemaking attached as **EXHIBIT 3.** Please reference RAC meeting notes posted on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress.

Written comments received during the RAC process note that parallel rulemaking related to SB 537 is required by the Oregon Occupational Safety and Health Agency (OR-OSHA) and OHA. Comments opine that both sets of rules should be consistent and request that the effective dates of OHA's rules and OR-OSHA's

rules align, making it easier and more cost efficient for facilities that are required to follow both sets of rules, noting that facilities would "value the compliance time and cost savings associated with a unified approach to SB 537 rulemaking."

Agency response: In response to written comments, the OHA has amended the rules to specify that the requirements for establishing, implementing, and maintaining a workforce violence prevention program and a flagging system will take effect on May 1, 2026. Given the uncertainty around when OR-OSHA will implement permanent rules, aligning the effective dates is not feasible.

In written comments received during the public comment period, OHA heard a request for clarification around the scope of intake risk assessments and hospital discharge coordination for hospice agencies (OAR 333-035-0165(2)(a) and (b)).

Comments refer to OAR 333-035-0165(2)(a)(A) that states "Any act or threat of physical violence, harassment, intimidation, assault, homicide or any other threatening behavior **where hospice services are provided to a patient;**" (2)(a)(D) "Whether the **patient** is willing to securely store any weapons that are present in the home health care setting before any visit from personnel."; and (2)(b) "Hospital discharge coordination. When a patient is discharged from a hospital and referred to a hospice program, the hospice program must develop and implement a plan to obtain **any known patient history of violence** within the last 12 months from the hospital as part of continuity of care."

Clarification is requested as to whether "hospices will be asking about the history or previous behaviors by only the ***patient*** or should they also be asking about history of violence or disruptive behaviors by the patient's family members or caregivers who will be in the home where hospice services are provided to a patient?"

Agency response: The legislative language in SB 537, section (12), subsection (2) provides that as part of the patient intake process, a hospice program must collect information necessary to identify and assess potential health and safety-related risks including workplace violence as defined in ORS 654.412 that may be encountered in the patient's residence. This language does not prohibit a hospice program from collecting information from persons other than the patient, rather

establishes minimum requirements necessary for the intake process. Hospice programs have the flexibility to establish a process that aligns with their operational needs and business model.

In written comments received during the public comment period, OHA heard the importance of the rules reflecting "SB 537's dual-safety framework, rather than framing protections for healthcare workers and protections for patients as competing interests." Regarding the concern about stigma, particularly around physical or visual flagging, written comments opine that "improved education and training in trauma-informed care and supportive communication can mitigate stigma while still ensuring that we act now to reduce the incidence and prevalence of workplace violence. Delaying or weakening safety protections in the name of avoiding stigma risks perpetuating harm rather than preventing it." Comments further opine that advance awareness of clinical risks such as "overstimulation, impaired cognition, untreated psychiatric symptoms, substance use, or a known history of aggression" ("clinical facts and not mere moral judgments") enables appropriate interventions to "reduce the likelihood of harm to both patients and clinicians."

Written comments state that the "intent of visual flagging under SB 537 is situational awareness, not labeling or penalizing patients." Comments also address the equity implications, noting that "home health and hospice workers are disproportionately women, people of color, and lower-wage healthcare workers who frequently work alone. Failing to provide meaningful safety protections in the name of avoiding stigma effectively shifts risk onto an already vulnerable workforce, raising serious equity concerns of its own."

Written comments address the legislative intent behind SB 537, stating that "a blanket prohibition on physical or visual flagging in community-based settings would undermine the bill's core principle of meeting people where they are with the supports necessary to keep people safe." Comments urge OHA to "adopt rules that support clinical judgment, prevention-focused care, and balanced protections for both patients and healthcare workers, rather than creating new barriers to safe practice."

Agency response: After considering all written comments and the discussions held with the RAC, the OHA concludes that these rules appropriately support clinical judgement, promote prevention-focused care, and provide a balanced set of protections for both health care workers and patients.

In oral testimony related to the cost of compliance impact on small businesses cited in the Statement of Need and Fiscal Impact, OHA heard the request for the agency to collect data yearly from home health agencies and hospitals on the number of employees and the number of patients. Comments opined that there could be some good uses for this type of yearly data collection.

Agency response: As the OHA, Health Care Regulation and Quality Improvement (HCRQI) section develops on-line licensing capability for each licensed facility type, it will engage with its licensed community members to identify additional data points that may be captured during the licensing process, such as number of employees, patient census, etc.

In oral testimony, OHA heard the request that any webinars that OHA offers about the SB 537 rulemaking include one for home health and hospice organizations, separate from one for hospitals, because it is a very different type of healthcare.

Agency response: The OHA, HCRQI section will work to ensure that webinar opportunities are made available according to licensed facility type.

In oral testimony, OHA heard the request for consideration around the requirement for bullet resistant construction at emergency department reception desks and the need to have physical contact between a staff member and a patient in order to place an armband on the patient after verifying identity to ensure there are no medical errors.

Agency response: Hospitals are required by the Centers for Medicare and Medicaid Services to maintain an effective system for patient identification to prevent medication errors and other potential harms; however, the use of

wristbands is not specifically mandated. When wristbands are selected as the method of compliance, hospital compliance officers, in coordination with hospital safety committees, should evaluate and determine the most appropriate and reliable process for applying those wristbands.

EXHIBIT 1

From: Brian Boggess
To: Mellony Bernal
Cc: Andi Easton
Subject: Hazard definition for SB 537 rules
Date: Friday, October 10, 2025 11:37:22 AM

Hi Mellony,
Thanks for the great work so far on these rules! We certainly appreciate all of the effort that happens behind the scenes.

I think adding a simple definition of "hazards" is a good idea, especially as opposed to spelling those hazards out in detail in the body of the rules. One trick will be determining if we should focus specifically on workplace violence related hazards or be more broadly inclusive. Some of this might also be more appropriately in the OSHA lane.

OSHA states that for home healthcare workers, **"hazards include bloodborne pathogens and biological hazards, latex sensitivity, ergonomic hazards from patient lifting, violence, hostile animals and unhygienic and dangerous conditions. In addition, if their daily work schedule requires them to provide care for multiple patients, they face hazards on the road as they drive from home to home."**

NIOSH has a 68-page pdf about home healthcare hazards. It's from 2010 but still useful.

Proposed definition for SB 537 RAC:

> **"Hazard" means potentially unsafe or dangerous conditions in or around the healthcare setting, including but not limited to the presence of uncontrolled animals, persistent or periodic presence of individuals with history of aggressive behavior or substance abuse, elevated rate of criminal activity, poor or unreliable cell phone coverage, and lack of law enforcement or emergency response capability.**

Technically, rodent or pest infestations would be included in the phrase "uncontrolled animals."

There are a number of other potential hazards in home healthcare settings, of course – musculoskeletal injuries from moving patients, allergic reactions, environmental

hazards like uneven terrain or falling trees and branches. All of those would be included in the mandatory training that is “consistent with NIOSH and OSHA” standards but we could include examples in the definition, if necessary.

Best,
Brian

Brian Boggess | Manager-Workplace Violence Prevention
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[redacted]

“Be joyful though you have considered all the facts.” – *Manifesto: The Mad Farmer Liberation Front*, **Wendell Berry**

Samaritan Health Services

From: Craig Rudy
To: Mellony Bernal; King Katie
Subject: Re: SB 537 RAC - FOLLOW-UP INFORMATION
Date: Friday, October 10, 2025 11:03:16 AM
Attachments: image001.png

Mel,

Thank you for your time and work today.

I have a specific area that I want to comment on for the next session (see page 44) - section 333-505-0045:
(C) Education and training for authorized staff on:

I want to clarify that the position of the Oregon Chapter of American College of Emergency Physicians has been that any mandated training may represent an undue burden on healthcare workers. In particular, many providers are contracted, private practice, or salary based. This means that any new mandated training represents additional work on top of other administrative and clinical responsibilities without additional compensation or protected time. Many clinicians already have a very full schedule and this would take away from other opportunities to help our patients. During the bill phase, we specifically discussed changing the language of "provide training" as the connotation means that this is available rather than a mandatory requirement. I would recommend that any comments regarding training use the language of "make available" or similar type of language. As an emergency physician who has been a victim of violence in the workplace (as have many of my colleagues), I think it is important to highlight that mandated training sessions are unlikely to improve our safety. While we support the importance of available training; mandatory training can be seen as potentially shifting the burden of safety from the patient, institution, and environment to the clinician. I also understand that this is likely to be discussed on the OSHA RAC but I think consistency in language is important.

Thank you for the consideration

Best,
Craig

On Thu, Oct 9, 2025 at 12:31 PM Mellony Bernal <MELLONY.C.BERNAL@oha.oregon.gov> wrote:

> In response to a request for additional information, the following rules will not be considered during this rulemaking process:
>
> OAR 333-027-0033, pg. 3

From: Emily Cronan
To: Mellony Bernal
Subject: SB 537 RAC Follow-Up
Date: Friday, October 17, 2025 11:29:15 AM

Hi Mellony,

SB 537's implementing rule should consider explicitly define "high-risk home visit" and require pre-visit screening, documentation, and employer-mandated mitigation. National guidance (OSHA, NIOSH, Joint Commission) identifies predictable, recurring hazards for clinicians performing home visits (weapons, prior violence, active substance use, uncontrolled animals, severe environmental hazards). A practical, operational definition (any one objective criterion triggers high-risk classification) will ensure consistent application across employers, enable timely protective measures (two-person visits, security escort, telehealth substitution), and create robust data for the consolidated incident reporting the statute requires.
This approach protects clinicians, aligns Oregon with national best practices, reduces employer liability, and gives regulators the objective measures they need to enforce protections and evaluate program impact.

Per your request during our last meeting, I have included some standardized definitions of "hazards" as it relates to home health and hospice. Specifically:

Section 21 (1)(A) Includes, but is not limited to, training on recognizing hazards that are commonly encountered by home health care staff in home health care settings and protocols for managing such hazards.

Directly from OSHA consumer facing website:

What are the hazards in home healthcare?
Home healthcare workers may be employed by a home care agency or may be self-employed independent contractors working directly for patients. They have little control over their work environment which may contain a number of safety and health hazards. These hazards include bloodborne pathogens and biological hazards, latex sensitivity, ergonomic hazards from patient lifting, violence, hostile animals and unhygienic and dangerous conditions. In addition, if their daily work schedule requires them to provide care for multiple patients, they face hazards on the road as they drive from home to home.

https://www.osha.gov/home-healthcare

As a compilation from The Joint Commision, AHRQ and CMS CoPs (home health and hospice):

https://digitalassets.jointcommission.org/api/public/content/68a29e1ff3304fb892a5b9257e7097ad?v=2109c28e&utm_source

Medication-related hazards — wrong drug/dose, missed doses, unsafe storage, inaccurate reconciliation at transitions of care (high risk for adverse drug events in home settings).
Sources: AHRQ primer on medication errors; AHRQ PSNet resources.

Falls & mobility-related hazards — environmental trip/slip hazards, lack of assistive devices, unsafe transfers, poor footwear, inadequate supervision. Falls are a leading cause of injury for older adults at home.

Infection prevention & control hazards — lapses in hand hygiene, contaminated supplies/lines, improper wound care or catheter care, lack of appropriate PPE or cleaning protocols (applies to both patient and worker safety). Guidance: CDC core practices and infection-control toolkits.

Environmental/home-safety hazards — fire/smoke, carbon monoxide, oxygen-related ignition risk, electrical hazards, inadequate lighting, cluttered walkways, structural hazards (stairs, loose rugs). Home-specific checklists and CMS survey guidance address these.

Medical equipment & device hazards — misuse/malfunction of oxygen concentrators, enteral pumps, IV infusion devices, home ventilators; inadequate maintenance or improper caregiver training. Joint Commission and CMS expect policies for safe use/education.

Clinical-process and documentation hazards — incomplete/unclear orders, poor care-plan communication, missing advance directives, delayed or inaccurate documentation leading to unsafe decisions at point-of-care or during transitions. AHRQ and CMS emphasize communication and care-transition safety.

Behavioral, cognitive, and caregiver-related hazards — patient confusion, dementia-related wandering, caregiver fatigue or burnout, inadequate supervision or training of family caregivers. Studies of hospice incidents note these as recurring contributors to safety events.

Workforce & occupational hazards (staff safety) — violence/hostile persons, animal attacks, bloodborne pathogen exposures, ergonomic injuries from patient handling, travel/transportation risks for staff. OSHA/NIOSH have specific guidance for home healthcare worker safety.

Emergency preparedness & disaster hazards — lack of plan for power loss (oxygen-dependent patients), severe weather, evacuation barriers, or pandemics. CMS CoPs and emergency-prep rule guidance require agency readiness.

Psychosocial & bereavement risks — unmanaged pain or distress, untreated depression/anxiety, inadequate bereavement support that can contribute to safety lapses (more relevant in hospice). NHPCO/NHPCO-derived standards discuss these programmatic hazards.

Thank you for your consideration,

Emily Ann Cronan, MSN, RN, CWCN, CHPN
(Pronouns: she/her/hers)
Nurse Practice Consultant
Oregon Nurses Association
[redacted]
Tualatin, OR 97062
[redacted]
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Hospital Staffing Complaint Enforcement

The Oregon Health Authority (OHA) will start assessing fines for complaints filed on or after June 1, 2025, where a hospital is found to be out of compliance with the staffing law. It is critical for nurses to file complaints to protect themselves, their coworkers, and their patients. Learn more at www.oregonrn.org/safestaffinglaw

Lynda Enos, RN
Independent consultant.
Oregon State Association of Occupational Health Nurses (OSAOHN)

Worker Safety Program Requirements

333-027-0115 Home Health and *333-035-0165 Hospice and* 333-071-0423 Special Inpatient Care Facilities

(4) Training. An agency shall provide annual training on worker safety. The training must be consistent with training for home health care workers, endorsed by the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration, and must include the following:

(a) Recognizing hazards that are commonly found by staff where home health care services are provided to a patient; and

(b) How to manage hazards that are identified.

Comment:
Is this addition to the required annual training in statue already i.e., SB 537 4(a) which includes a list of very specific WPV training requirements for covered entities?

Should there be a statement that these training requirements are in *addition* to the requirements already stated in ORS 654.414(now SB537) 4(a)

(5) Quarterly safety assessments. An agency must conduct quarterly safety assessments with staff who have been assigned to provide home health care /hospice services.

Comment:
I think clarification is needed to define a 'safety assessment.'
Is this a review of each client's home and care situation for risk of violence?
Is it a review of the workplace violence protocols that a home health or hospice agency has implemented?

Special Inpatient Care Facilities 333-071-0205
(5) Quarterly safety assessments. A freestanding hospice facility must conduct quarterly safety assessments with staff who have been assigned to provide hospice services.

Comment:
I think this also needs to be clarified.

The type of assessment in an inpatient facility would be somewhat different to those that can be conducted in a home care situation.

Is this an assessment of the patients in care are a specific time when the assessment is conducted and/or is it an assessment of WPV protocols etc?

333-027-0115 Home Health and *333-035-0165 Hospice*

(7) Safety checks. An agency/ hospice facility must provide a mechanism by which staff can perform safety checks, including through use of a mobile application to access relevant safety related information identified under sections (1) and (2) of this rule.

Comment: I am not sure what happened to the existing statute below – it is not in SB 537

Existing statue as of 2023 states

ORS 654.421 Refusal to treat certain patients by home health care employee. (1) An employee who provides home health care services may refuse to treat a patient unless accompanied by a second employee if, based on the patient's past behavior or physical or mental condition, the employee believes that the patient may assault the employee.

(2) An employee who provides home health care services may refuse to treat a patient unless the employee is equipped with a communication device that allows the employee to transmit one-way or two-way messages indicating that the employee is being assaulted. [2007 c.397 §6]

Can the rules address the issue of home care and hospice workers needed a way to call for help (when cell services don't work etc) and for employers to know where they are if they don't check in at the end of their shift?

Special Inpatient Care Facilities 333-071-0205

(7) Safety checks. A freestanding hospice facility must provide a mechanism by which staff can perform safety checks, including through use of a mobile application to access relevant safety related information identified under sections (1) and (2) of this rule.

Comment: This is the same language used for home health and hospice. Is it needed for a freestanding facility where there should be easy access to a patient's chart?

333-027-0115 Home Health and *333-035-0165 Hospice*

Potential Threat or Disruptive Behavior Flagging Systems

> **(d) "Visual flags" means paper-based physical cues, including wristbands, signage, color-coded indicators, symbols and other visible cues built within the care environment to facilitate immediate recognition of potential threats of violence or disruptive behavior without having to access an electronic health record.**

Comment: The suggestions for visual flagging are relevant and commonly used in an inpatient facility, however, I am not sure if these examples are relevant to home health and hospice. I am interested to hear

what the representatives from these areas think? For example, signage is not appropriate for a home setting, and I am not sure that colored arm bands are either.

For all entities:

Comment: Related to all language about "Visual flags". Is it possible toad language that states the visual flags used must not stigmatize the patient.

For example, a standardized orange symbol on a patient's room door or an orange arm band that is standardized to mean the patient is at risk for violence is preferable to a sign that overtly indicates the risk of violence using text or icons.

For all entities:
(4) Providers and staff of an agency may not take any of the following actions based solely on the presence of an EHR flag:
(g) Punish or penalize the patient.

Comment: this is subjective and up to interpretation by the patient and/or their family. I know it's stated in SB 537, but I would like to know if others feel this statement requires further clarification.

Division 71
Special Inpatient Care Facilities

333-071-0423
Worker Safety Program Requirements
1 Patient intake risk assessment

(a) Presence of pet(s) and if any, whether the pet(s) can be secured away from the area where care is provided, if requested by staff;
(b) Possible pest infestations, for example, rodents or insects; and
(c) Presence of weapons and if any, whether the patient is willing to securely store them before a staff visit.

Comment: Does this apply to a free-standing facility?

333-071-0425
Potential Threat or Disruptive Behavior Flagging Systems

(3) An SICF classified as a rehabilitation hospital or a freestanding hospice facility is responsible for establishing protocols and procedures for implementing and using flagging systems that must address, at a minimum, the following requirements:

Comment: this is the only time a rehabilitation hospital is mentioned in the proposed rules – shouldn't all WPV related-rules for freestanding hospice facility apply to a SICF classified as a rehabilitation hospital?

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November 3, 2025

Mellony Bernal
Legislative and Administrative Rules Policy Analyst
Oregon Health Authority
800 NE Oregon Street, Suite 465
Portland, OR 97232

Re: SB 537 Workplace Violence Prevention Safety Requirements in Health Care Settings Rules Advisory Committee (RAC)

Dear Mellony,

Thank you for the opportunity to provide comments on the proposed rulemaking related to SB 537 and associated provisions. We appreciate the Oregon Health Authority's (OHA) efforts to improve safety and care standards across healthcare settings. However, we respectfully submit the following recommendations to support practical and equitable implementation.

General recommendation: We request that any proposed rules unrelated to SB 537—such as the written language and SOGI changes in OAR 333-505-0036—be considered separately as they extend beyond the scope of this legislation.

Home Health – OAR 333-027-0125: While visual indicators may be suitable in facility-based environments where they can be consistently monitored, they are impractical in-home health or hospice settings. Requiring patients to display such indicators on private residences may be stigmatizing and unreliable. In contrast, Electronic Health Record (EHR) flagging offers a consistent, respectful, and agency-controlled method for safety alerts.

> **Recommendation:** Remove subsection (b) requiring visual flags for home health settings and instead rely solely on EHR-based flagging systems to ensure effective and equitable implementation.

Law Enforcement Disclosure – OAR 333-505-0045, 333-035-0167, 333-071,0425, 333-505-0045(4)(e):
This section prohibits providers and staff from contacting, reporting or disclosing information to law enforcement based on the presence of an EHR flag. However, the rule

lacks clarity regarding the circumstances under which agencies may contact or disclose information to law enforcement. Clear guidance is essential to ensure compliance with legal standards and protect patient confidentiality.

> **Recommendation:** Provide clarification on permissible circumstances for law enforcement contact to ensure appropriate implementation.

Satellite Facilities – OAR 333-500-0025(h): Requiring both visual and EHR flagging systems in satellite facilities may be overly burdensome and impractical, particularly in fast-paced clinic environments where patients may only be present briefly. Visual cues in such settings are unlikely to prevent incidents effectively.

> **Recommendation:** Revise the rule to require EHR flagging, with optional use of visual flags where applicable:
> *(h) The satellite in in compliance with OAR 333-505-0045 relating to workplace violence prevention **EHR** flagging systems **with optional use of visual flags where applicable.***

Potential Threat of Disruptive Behavior Flagging System – OAR 333-505-0045, 333-035-0167, 333-071,0425, 333-505-0045 (L):
Flagging at initiation is the most critical time to flag. Requiring separate clinical documentation in the patient's EHR for continuation, inactivation and reactivation is not related to patient care and is an administrative burden. Often, the justification is embedded within the flag itself.

> **Recommendation:** Revise the requirement to allow for supporting clinical documentation, rather than a linked note, ensuring alignment with ADA standards and minimizing administrative burden.
> *(L) Requiring that every flag-related action, including but not limited to initiation, ~~continuation, inactivation or reactivation~~, be supported by **clinical documentation** ~~a linked clinical note~~ that documents the justification for the action.*

Flagging Systems - OAR 333-505-0045, 333-035-0167, 333-071,0425, 333-505-0045 (4)
Section 4 includes a list applicable to both virtual and EHR flagging systems but only indicates they are related to an EHR flagging system.

> **Recommendation:** Add that this section applies to visual flags.
> *(4) Providers and staff of an agency may not take any of the following actions based solely on the presence of an EHR or **visual** flag.*

Waivers - OAR 333-071-0260

SCIF is defined in Section 3; in addition to the requirements specified in section 1, an SICF classified as a freestanding hospice facility shall provide worker safety training in accordance with OAR 333-071-0423.

> **Recommendation:** Move the definition of SCIF to OAR 333-071-0205 and remove it from 333-071-0260 for clarity.

Inclusive Flagging Language – OAR 333-505-0045, 333-035-0167, 333-071,0425, 333-505-0045 (M)
Given the prevalence of healthcare violence, especially in pediatric settings, flagging systems should reflect the full scope of clinical interactions.

> **Recommendation:** Expand flagging criteria to include "patient, caregiver, or support person".
> *(M) Establishing a process by which a patient, **caregiver** or a person authorized to make health care decisions on behalf of the patient, may request review and removal of an EHR flag.*

We appreciate the opportunity to provide input on costs and racial equity. Providence has identified costs associated with ballistic glass requirements and training. Regarding racial equity, we are evaluating potential bias in flagging systems and exploring strategies to mitigate disparities proactively, ensuring our commitment to equity is upheld.

Thank you for your attention to these concerns. We look forward to continued collaboration to ensure that the final rules are both effective and practical for implementation across diverse healthcare settings.

Sincerely,

Wendy Trapp, MHA, PMP

Wendy Trapp, MHA, PMP
Senior Program Manager
Providence Health & Services

Emily Bennett, MN RN, NC-BC, COS-C

Emily Bennett, MN RN, NC-BC, COS-C
Performance Improvement Manager
Providence Home Health Oregon

From: Karen R. Reed
To: Mellony Bernal
Subject: RE: Action needed by Noon, 11/5 - Follow-up from October 24 SB 537 RAC meeting
Date: Tuesday, November 4, 2025 1:33:38 PM
Attachments: attachment-1.png
attachment-2.png

Hello,
Thank you for allowing me the opportunity to participate in this process. It has been very thought-provoking! I appreciate the variety of folks who have offered perspectives.

In response to your questions…

1. **How will adoption of the proposed rules affect racial equity in the state?** While I don't feel truly qualified to answer this question…I do know that in Oregon, black and native American persons are incarcerated at a significantly higher rate than whites. I'm guessing that the reasons behind that statistic are complex. But what I have seen in my career in healthcare is that whether or not a person is seen as "threatening" is highly variable to the individual experiencing the situation. I can see where these perceptions that someone may or may not be a risk for disruptive or violent behaviors could easily be inconsistent. With that in mind, I would fully expect that racial or ethnic inequities will be a result.
   As far as mitigating this issue…I would say that any efforts to make the process as objective and consistent as possible would be necessary.

2. **What do you see as the fiscal and economic impact of these rules?** I would see the fiscal impact to be…
   a. Development and implementation of training for staff. (this may be the greatest cost….as a critical access hospital with limited expertise in identification of potentially threatening behavior (versus someone experiencing a temporary situation causing them to act out), defining triggers and appropriate mitigating strategies, mental health disorders and interventions, compassionately setting boundaries, de-escalation, etc etc etc, the development of thorough and effective training could be a burden.
   b. Development and implementation of training for "program administrators"
   c. Development of process for tracking and review for consistency, appropriate intervention, and continuation/discontinuation could be costly. We do not currently have capability within our EMR to run a report on flags, so would have to create a manual process.
   d. The requirements for bullet-proof glass with any new construction/remodel would add to the cost, though I cant speak to the exact impact.

We do have an ethical, more and legal obligation to protect our staff….and our patients, so I think we are having the right conversation.

Thank you!
Karen

Karen Reed, MBA, MSN, RN
Director of Quality/Risk/Compliance
Harney District Hospital
[redacted]
Burns, Oregon 97720
[redacted]

Harney District Hospital
Enriching Lives
Through Better Health

From: Mellony Bernal [mailto:MELLONY.C.BERNAL@oha.oregon.gov]
Sent: Tuesday, October 28, 2025 5:38 PM
[redacted]

[redacted]

Cc: HALL Brittany A <Brittany.A.HALL@oha.oregon.gov>; Em Droge (she/they) <Emily.Droge@oha.oregon.gov>; Walker Charina <CHARINA.WALKER@oha.oregon.gov>
Subject: Action needed by Noon, 11/5 - Follow-up from October 24 SB 537 RAC meeting
Importance: High

Thank you for your continued participation in the SB 537 Workplace Violence Prevention Requirements in Health Care Settings Rule Advisory Committee (SB 537 RAC). As discussed in the meeting, the Health Care Regulation and Quality Improvement (HCRQI) section is canceling the November 3, 2025 meeting to allow time for staff to review comments, consider changes, and follow-up as needed to determine whether there is statutory authority to make some of the suggested changes.

The next RAC meeting will be held Monday, November 10, 2025 from 9-11 a.m. A Microsoft Teams meeting invite will be forwarded shortly.

The meeting notes from the October 24, 2025 meeting are attached and will be posted at http://www.healthoregon.org/hcrqirules under "Rulemaking Advisory Committees in Progress."

Lastly, as a requirement under the Administrative Procedures Act, and the OHA policy on RACs, the HCRQI section is seeking your feedback on the following questions. Please submit your comments by email to mellony.c.bernal@oha.oregon.gov or please reply all to this email, **no later than Wed., November 5th by Noon** so that we can prepare the final document for your review on November 10.

1) **How will adoption of the proposed rules affect racial equity in this state?** Consider which populations are affected or most harmed from a racial equity perspective and identify how or in what specific ways are racially/ethnically specific communities affected by the rule, and how the rules might mitigate any potential negative impacts to racial equity.
2) **What do you see as the fiscal and economic impact of these rules to your facilities?** Consider factors such as training requirements, equipment needed, changes to physical environment, software upgrades, record keeping, increased administration costs, etc.

With appreciation,

Mellony Bernal
Legislative and Administrative Rules Policy Analyst
971-673-3152
Public Health Division, Health Care Regulation and Quality Improvement
OHA, PHD Customer Service Survey

www.healthoregon.org/hflc
www.healthoregon.org/ems

OREGON HEALTH AUTHORITY

DRO | Disability Rights Oregon

TO: Oregon Health Authority

FROM: Disability Rights Oregon

DATE: November 5, 2025

RE: Concerns Regarding Proposed Rules Implementing SB 537

During the Oregon Legislature's 2025 Regular Session, the Legislature passed SB 537. In relevant part, SB 537's Section 9 required that all "covered entities"—here meaning all hospitals, home health care providers, and hospice providers—must "implement flagging systems" to "communicate potential threats of violence or disruptive behavior." S.B. 537, § 9 (2025).

We endorse efforts to keep patients and providers safe, but the proposed rules require health care organizations to adopt a rigid framework for flagging patients deemed dangerous. Large racial disparities are common in the implementation of such systems, with no demonstrated benefit to staff safety. The implications of these rules sweep widely.

First, the one-size-fits-all rule amendment *requires* all hospitals, all home health agencies, and all home hospice programs to adopt a health record flag system, whether the agency needs it or not. A pediatric hospice program, for instance, would be required to enact a wide array of safety protocols, engage in training, and develop communication plans, even if they have never had a problem of workplace violence and even if their primary role is treating elementary school-aged children with cancer and other terminal conditions. That hospice program is just as bound by these rules as Unity Hospital or the emergency department at a major city hospital. The proposition is wildly overbroad in its scope. Agencies and hospitals should not be *forced* to adopt such a system, particularly where such a system has no demonstrable applicability to their services.

Second, the use of these programs has in practice routinely results in systematic racial disparities in how the flags apply, with Black patients being flagged twice as

often as white patients.[1] Associated with the racial disparities in behavioral flags were greater waiting times, less time in contact with a clinician, less laboratory testing and less use of advanced imaging, and more multi-pharmaceutical prescriptions. *Id.* (table 2). In brief, Black patients flagged by the system got longer waits, less treatment, and worse care.

Any benefit of these flagging systems also do not justify the problems they create. In a systematic review of nurses working in hospitals with such flagging systems indicated that those "nurses were skeptical of the ability of flags to prevent violence from occurring and noted concern for the unintended consequences of introducing bias into patient care."[2] A majority of nurses surveyed "viewed flags as unhelpful, noting that actual patient discipline 'never happens' or the presence of a flag 'doesn't change anything.'" *Id.* In other cases, nurses reported the flags were posted arbitrarily by staff who had themselves escalated the incident or patients who had experienced long wait times or frustrations associated with larger dysfunction in the medical world. *Id.* In response to these valid concerns, the proposed rule says nothing more than that hospitals and home health agencies must have a plan including some unenumerated training requirements on "identifying and preventing bias in the assignment of [electronic] flags." Proposed OAR 333-027-0125(3)(a)(D); Proposed OAR 333-505-0045(3)(a)(D). Even that minimal requirement is absent from the equivalent section on visual flags.

The proposal for visual flags is frustratingly vague as it relates to home health care. Unlike a hospital, where the provider typically owns or at least controls the premises, a home health care agency necessarily serves a person in their own home. The agency has no right to require a person to post a visual flag on the premises of their own home or to require a person to wear a stigmatizing bracelet, badge, or other item in the privacy of their own home. A person has a right to be free from government-imposed "compelled speech," particularly where the speech is neither "purely factual" or "uncontroversial." *Nat'l Ass'n of*

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[1] Agarwal et al., Prevalence of Behavioral Flags in the Electronic Health Record Among Black and White Patients Visiting the Emergency Department, 3 JAMA Netw Open 6 (Jan. 2023) *available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC9857105/ (review of over 400,000 ED visits showed that Black patients were flagged at twice the rate of white patients); *see also* Sun *et al.*, *Negative Patient Descriptors: Documenting Racial Bias in the Electronic Health Record*, 41 Health Affairs 203 (Feb. 2022) *available at* https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01423 (negative comments in electronic charts significantly more frequently directed at Black patients than white patients).

[2] Seeburger et al., *Qualitative Perspectives of Emergency Nurses on Electronic Health Record Behavioral Flags to Promote Workplace Safety*, 3 JAMA Netw. Open 6 (Apr. 2023), *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2803958

Wheat Growers v. Bonta, 85 F.4th 1263, 1283 (9th Cir. 2023) (glyphosphate chemical dealers could not be forced to publish on their own products a warning of a "potential risk"). An affected person, forced to wear a wristband designating them as unsafe or to have a sign designating them as dangerous posted on their apartment door, might very well disagree with the subjective assessment. SB 537 and the proposed rules require the application of visual flags but pose no theory of a constitutionally acceptable means of achieving that goal.

Visual flags include "paper based physical cues, including wristbands, signage, color-coded indicators, symbols, and other visual cues *built within the care environment*." Proposed OAR 333-027-0125(1)(d). The rule provides no parameters, nor any explanation, for how a home health care agency can be governmentally compelled to force a person in the privacy of their own home to wear a badge or wristband identifying that person as "dangerous," or to post on their door or walls a signs or other indicators that they are a hazard, particularly when that person objects to that categorization. Based on the descriptor of the visual cues, such visual flags would all be visible to any visitors to the patient's home and many (such as signage) might be visible to passersby in one's apartment building or other such setting. Because many people receive home health care for dozens of hours a week, the burden of this government-mandated labeling might not be brief or easy to conceal from third parties.

Similar and related theories could be advanced about promoting public stigmatization of people with disabilities under the ADA and other nondiscrimination laws. Obviously, publicly labeling people with disabilities as dangerous could threaten their wellbeing, their housing, and their dignity, particularly when done with little process in a highly subjective manner.

The justification for such a visual flag in home health care is hard to understand. In the context of a hospital, dozens of providers may find themselves suddenly coming in contact with a patient, whether because the patient has wandered, the patient sees numerous specialists making often unpredictable visits (such as physical therapists, social workers, chaplains, etc.), or more staff have been called to assist in an emergency. A hospital patient cannot be guaranteed to see only their primary treating staff, nor can staff be guaranteed to come in contact only with patients whose charts they are familiar with. In the context of home health and hospice, a patient will as a matter of course only see the home health provider(s) sent out that day. In the context of home health care and home

hospice care, routine scheduled providers will know for days or hours in advance which home care patients they will see and have ample time to familiarize themselves with a medical record, including any such flags. Even if substitute or supplemental home health care staff are called in, they will have ample time to hear about any risk posed by the patient in transit. Considering the gravity of the imposition of this serious burden on one's First Amendment rights, the proposed rule should be grounded in a more substantial state interest.

Last, the proposed rule has many protocols and requires many steps—but contains little detail for getting an innocent or rehabilitated patient *off* the list of flagged patients. An affected agency or hospital must only "[e]stablish[] a process by which a patient, or a person authorized to make health care decisions, may request review and removal of an EHR flag." Proposed OAR 333-027-0125(3)(a)(M); Proposed OAR 333-505-0045(3)(a)(M). The subsection on visual flags contains no such right at all, only vaguely requiring some process for "initiation, continuation, inactivation and reactivation of visual flag," not even guaranteeing an individual right to contest the visual flag. Proposed OAR 333-027-0125(3)(b); Proposed OAR 333-505-0045(3)(b). A hospital or health care provider could adopt the most limited policy it likes to implement this requirement, such as by requiring 20 years to pass from the last behavioral incident before lifting such an EHR flag would even be considered. The proposed rule would, on its face, allow an agency or hospital to refuse entirely any individual request to halt a visual flag. The proposed rule imposes no limitation on any such policy, just that it exist. The proposed rule would leave patients, particularly in rural areas where few health resources exist, at the mercy of the most unreasonable or most suspicious staff member of the local health care agency, with little or no practical means to challenge the designation as a behavioral problem. This proposal—to require by state law the creation of a public and visible sign of stigma in the delivery of health care with no specific due process protections to escape it—is of dubious legality and constitutionality.

At this time, "little is known about [the] utility, effectiveness, or potential for unintended consequences on care" of such flagging systems. Seeburger *et al.* In the absence of any evidence that these flags actually increase staff safety or that any benefit is not outweighed by increased harm to patients who are Black or have disabilities, the proposal to require every hospital, home care agency, and hospice service to adopt an unproven and potentially harmful technology—at substantial cost in money and time—does not merit legislative action.

Improvements in overall staffing, physical safety precautions, improved training, and greater mental health supports are all alternative means of improving staff safety with a higher likelihood of success.

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Nov. 12, 2025

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Re: SB 537 Workplace Violence Prevention Safety Requirements in Health Care Settings Rules Advisory Committee (RAC)

Dear Mellony,

Thank you for the opportunity to provide comments on the proposed rulemaking related to SB 537 and associated provisions. We appreciate the Oregon Health Authority's (OHA) efforts to improve safety and care standards across health care settings and for considering our comments presented in our Nov. 3 letter in the Rules Advisory Committee meeting on Nov. 10.

However, pursuant to our letter, please again consider the following revision. We have consulted with front line caregivers and other health systems and respectfully request the following recommendation from our earlier letter be included in the final adoption:

Potential Threat of Disruptive Behavior Flagging System – OAR 333-505-0045, 333-035-0167, 333-071,0425, 333-505-0045 (L):
Flagging at initiation is the most critical time to flag. Requiring separate clinical documentation in the patient's EHR for continuation, inactivation and reactivation is not related to patient care and is an administrative burden. Often, the justification is embedded within the flag itself.

> **Recommendation:** Revise the requirement to allow for supporting clinical documentation, rather than a linked note, ensuring alignment with ADA standards and minimizing administrative burden.
> *(L) Requiring that every flag-related action, including but not limited to initiation, ~~continuation, inactivation or reactivation~~, be supported by **clinical documentation** ~~a linked clinical note~~ that documents the justification for the action.*

We appreciate the opportunity to provide input on costs and racial equity. Regarding racial equity, we are evaluating potential bias in flagging systems and exploring strategies to mitigate disparities proactively, ensuring our commitment to equity is upheld.

Thank you for your attention to these concerns. We look forward to continued collaboration to ensure that the final rules are both effective and practical for implementation across diverse healthcare settings.

Sincerely,

Wendy Trapp, MHA, PMP

Wendy Trapp, MHA, PMP
Senior Program Manager
Providence Health & Services

Emily Bennett, MN RN, NC-BC, COS-C

Emily Bennett, MN RN, NC-BC, COS-C
Performance Improvement Manager
Providence Home Health Oregon

From: Mark Sohm
To: Mellony Bernal
Subject: Language concern for Flagging
Date: Wednesday, November 12, 2025 2:59:14 PM
Attachments: image001.png
Outlook-u22tpfwj
Outlook-u2uwxfhi.png

Hi Melony,

Thank you again for the opportunity to participate in the RAC process.

I have one last suggestion and hope it is before the deadline. With regard to the requirement of a linked progress note for violence risk flags there are a few concerns.

- EPIC does not seem to allow for a direct electronic link in our flags and I am unsure if the developer will ever add that to a plain text field.
- Some behavior is exhibited prior to triage which may be outside the RN's ability to actually chart it.
- We flag visitors and significant others and parents of patients for aggressive behavior along with date/time,location, etc. archiving once that sig other is no longer a part of their life but still comes as part of the patient's package. A progress note will not be entered for a visitor.

I am hoping for a language change from a requirement to: "whenever possible, a reference to a progress note from the chart will be added to the flag entry."

Thanks again, You and your team did a great job with such a large group!

Mark Sohm | VIW Prevention Program Manager | Legacy Health
[redacted] | Vancouver WA 98686 | [redacted] | [redacted] | [redacted]

For support options for managers and staff, please visit our website:
Workplace Violence Prevention Office

From: Mark Bonanno
To: Mellony Bernal
Subject: Public Comments for the SB 537 RAC
Date: Wednesday, November 12, 2025 3:06:25 PM

To: Mellony Bernal, OHA Legislative and Administrative Rules Policy Analyst

From: Mark Bonanno, Oregon Medical Association, RAC Member

Re: Public Comments for the SB 537 RAC

Thank you for inviting feedback through a Rules Advisory Committee (RAC) for rulemaking related to Senate Bill 537 and workplace violence prevention for health care employers.

The Oregon Medical Association (OMA) represents the interests of physicians and physician associates statewide. We recognize there is a need to bring balance to efforts to reduce workplace violence in health care settings for clinicians and staff against imposing too much regulatory burden on facilities that remain financially challenged in the wake of a global pandemic only five years ago.

The OMA supports the work of our colleagues on the RAC from the Oregon Chapter of the American College of Emergency Physicians (Oregon ACEP) as well as the Oregon Pediatric Society.

Throughout the RAC process we heard helpful input about the ongoing work needed to understand root causes of workplace violence and efforts to reduce incidents and keep not only clinicians and staff safe but patients and their families as well. In addition to the administrative work called for in the rules including the pieces about training, we believe more work is needed with the partnership of the state to help bring enhanced clinical resources to bear in facility settings such as hospital emergency departments so that skilled psychiatric clinicians trained to respond to situations where workplace violence may occur become more available across the state. Like most states, Oregon is facing a physician shortage especially in psychiatric care.

With respect to training, there were comments made throughout the RAC about

mandating training. The comments from Oregon ACEP about the legislative history of the statute seem to be on point. When the rule calls for documenting training, that seems to add a mandated component not called for in the statute so we believe that in the final legal review by agency counsel, that addition should be reviewed for consistency with the statute.

We inquired about the parallel rulemaking authority related to SB 537 for the Oregon Occupational Safety and Health Agency (Oregon OSHA) and the timeline for their proposed rules. We learned the agency follows a different process from a RAC and draft SB 537 rules are not ready for review yet. We repeat a comment that both sets of rules should be consistent and perhaps the OHA process should be delayed slightly to align OHA and Oregon OSHA effective dates should inconsistencies be identified in the separate rulemaking processes. We expect that the facilities required to follow both sets of rules would value the compliance time and cost savings associated with a unified approach to SB 537 rulemaking.

In closing, we are open to continuing the discussion about reducing workplace violence in health care settings and also wonder if there is a role for the Oregon Patient Safety Commission in identifying evidence-based best practices in workplace violention prevention. Thank you for the work that has gone into the rulemaking process and for taking the time to engage stakeholders through a publicly accessible RAC process.

Mark

Mark A. Bonanno, JD, MPH
General Counsel and Vice President of Health Policy
Oregon Medical Association
[redacted]

From: Brian Boggess
To: Mellony Bernal; Selover Dana S; Anna L Davis
Subject: RE: Follow-up - Rules and Statement of Need and Fiscal Impact for 11/10 meeting
Date: Wednesday, November 12, 2025 3:40:26 PM
Attachments: image003.png

Good afternoon,
We are undertaking a final review of the proposed rules and found something that I thought was addressed in one of our early meetings but was not highlighted or reviewed on Monday.

On page 9, under the section regarding flagging systems, there is this language:

> **(J) Requiring that every flag-related action, including but not limited to initiation, continuation, inactivation or reactivation, be supported by a linked clinical note that documents the justification for the action.**

The specific requirement for a **"linked clinical note" is an unnecessary and unrealistic burden**. The observed behaviors that prompt application of a flag may be documented in a variety of ways, including security reports and RLDatix or similar files. For example, a patient who arrives at a hospital or clinic without an appointment, screams threats at a receptionist, and breaks furniture in the waiting room before departing the premises would not have a clinical note associated with that visit. Based on that behavior, though, an organization would be justified in applying a flag to that patient's chart to alert staff members of appropriate precautions that should be taken, e.g., two person staffing, avoidance of known provocations, known effective mitigating or de-escalating techniques, etc.

Proposed language:

> **(J) Requiring that every flag-related action, including but not limited to initiation or reactivation, be supported by documentation for the action.**

Respectfully,
Brian

Brian Boggess | Manager-Workplace Violence Prevention

[redacted] | Corvallis, OR 97330
[redacted]
WorkplaceViolencePrevention@SamHealth.org
[redacted]

“Be joyful though you have considered all the facts.” – *Manifesto: The Mad Farmer Liberation Front*, **Wendell Berry**

To: Mellony Bernal
Legislative and Administrative Rules Policy Analyst
Oregon Health Authority
800 NE Oregon Street, Suite 465
Portland, OR 97232

From: Odalis Aguilar Aguilar
Political Coordinator
Oregon AFSCME

Re: SB 537 Workplace Violence Prevention Safety Requirements in Health Care Settings
Rules Advisory Committee (RAC)

Good afternoon,

Thank you for the opportunity to provide feedback for the Workplace Violence Prevention Safety Requirements in Health Care Settings RAC. Oregon AFSCME is committed to ensuring that SB 537 is implemented in a way that matches with legislative intent. We appreciate the thoughtful process thus far and offer the following suggestions to ensure we are keeping workers and patients receiving services safe.

Generally we agree with the proposed suggestions to ensure health care environments are safe. During the RAC, the inclusion of satellite locations was discussed and it's our intent to ensure that these satellite locations will be in compliance and implement the 333-505-0045 rules. While we acknowledge that some environments may be faced paced, we also need to ensure that these environments are safe for both health care workers and patients to be able to receive the care they need. We urge the authority to maintain the current proposed language from the 11.7.25 draft under 333-505-0045:

> *(h) The satellite is in compliance with OAR 333-505-0045 relating to potential threat or disruptive behavior flagging systems;*

Health care workers at satellite locations for hospitals deliver critical work for patients. As their employer is the same and are under the ownership and control of the hospital, we believe the same requirements should apply in order to extend patient and worker safety.

Respectfully,

Odalis Aguilar Aguilar
Oregon AFSCME

EXHIBIT 2

From:	hansen@oregonhospice.org
To:	Public Health Rules
Cc:	"Barb Hansen"
Subject:	Written comments regarding Proposed Rulemaking: Workplace Violence Prevention Safety Requirements in Healthcare Settings and Administrative
Date:	Thursday, December 18, 2025 1:46:51 PM
Attachments:	image002.png

To: OHA - Public Health Division
Mellony Bernal
800 NE Oregon St. Suite 930
Portland, OR 97232

Regarding: Workplace Violence Prevention Safety Requirements in Healthcare Settings and Administrative Updates for OAR chapter 333, division 035

Hello Ms. Bernal,

I am submitting these written comments in addition to the oral comments I made during the public hearing that took place on Tuesday, December 16th, 2025. During a meeting about the proposed Workplace Violence Prevention rules with hospice provider members held yesterday afternoon (Wednesday, Dec. 17th, 2025), a question was asked that I was not sure how to answer. I now realize there is confusion about the wording of the proposed rules regarding the "Intake Risk Assessment" on page 17 of 52 under the section 333-035-0165 Personnel Safety Program Requirements, sections (2). I have copied this section of the proposed rules below.

333-035-0165
Personnel Safety Program Requirements
(2) A hospice program shall establish, implement, and maintain a workforce violence prevention program that includes, but is not limited to, the following requirements:
(a) Intake risk assessment. A hospice program must collect information necessary to identify and assess health and safety-related risks and hazards in a home health care setting, including but not limited to:
(A) Any act or threat of physical violence, harassment, intimidation, assault, homicide or any other threatening behavior **where hospice services are provided to a patient**;
(B) Presence of pet(s) and if any, whether the pet(s) can be secured away from the area

where care is provided, if requested by personnel;
(C) Possible pest infestations, for example, rodents or insects; and
(D) Whether the **patient** is willing to securely store any weapons that are present in the home health care setting before any visit from personnel.
(b) Hospital discharge coordination. When a patient is discharged from a hospital and referred to a hospice program, the hospice program must develop and implement a plan to obtain **any known patient history of violence** within the last 12 months from the hospital as part of continuity of care.

Essentially, the question comes down to this: during the Intake Risk Assessment, will hospices be asking about the history or previous behaviors by only the *patient* or should they be also asking about history of violence or disruptive behaviors by the patient's family members or caregivers who will be in the home where hospice services are provided to a patient?

(2)(a)(A) clearly states "*where* services are provided to the patient", so this would presumably include the history or actions by caregivers or family members who are present where these services are provided.
But (D) states "whether the **patient** is willing to securely store any weapons, etc." and if the patient is unable to do this, should we assume that it would be the family members/caregivers in the home we would be asking to do this?
And (2)(b) states "the hospice program must develop and implement a plan to obtain **any known** *patient* **history of violence** within the last 12 months from the hospital". What if it was not the patient who had been violent during a hospital stay but instead it was their spouse or other family member/primary caregiver who had been violent or demonstrating disruptive behaviors? Should hospices be asking about the history of violence about the patient *and* anyone else associated with the patient who may be present where hospice services are provided to a patient?

On behalf of hospice providers around the state, I know it would be appreciated if additional clarity could be provided in the proposed rules language about the scope of the Intake Risk Assessment.

Respectfully submitted,
Barb
Barb Hansen, MA, RN
CEO

Post Office Box 592 https://stopaapihate.org/
Marylhurst, OR 97036
[redacted]
[redacted]
www.oregonhospice.org
Pronouns: she/her/hers why this matters

December 22, 2025

CareOregon & Housecall Providers Comments on 333-035-0167

Thank you for the opportunity to provide comments in response to the proposed rule language regarding Workplace Violence Prevention Safety Requirements. Below are comments on behalf of CareOregon and Housecall Providers in response to proposed changes to 333-035-0167 Potential Threat or Disruptive Behavior Flagging Systems.

333-035-0167 (2) requires hospice providers to identify potential threats or violent behavior in the EHR and utilize a flag system as a physical cue- "including wristbands, signage, color-coded indicators, symbols and other visible cues built within the care environment to facilitate immediate recognition of potential threats of violence or disruptive behavior without having to access an electronic health record." While Housecall Providers already utilizes flags in our EHR, we have concerns around operationalizing a visual flag in an in-home hospice environment. Specifically, it would be challenging to operationalize the physical flag in a "respectful, and non-stigmatizing manner" as required by the rule, as it would likely require placing a label on the front door of a patient's personal home or having providers explain why the patient must wear a color-coded bracelet. Bracelets could also be lost or easily removed by confused patients.

We understand and agree with OHA's intent and believe we can maintain the desired level of safety utilizing EHR flags alone for home-based hospice. We recommend:

1. Removing the physical flag requirement, or
2. Making an exception for home-based hospice and specifying in rule that an EHR flag review must be conducted prior to hospice program staff entering a patient's home, which is already standard practice at Housecall Providers.

Please let me know if you have any questions about our feedback or if I can provide any clarification.

Sincerely,

Stefan Shearer
Senior Public Policy & Regulatory Affairs Specialist
CareOregon

TRAVIS NELSON
STATE REPRESENTATIVE
HOUSE DISTRICT 44
NORTH/NORTHEAST PORTLAND

HOUSE OF REPRESENTATIVE

December 22, 2025

ATTN: Brittany Hall
OHA - Public Health Division
800 NE Oregon St. Suite 930
Portland, OR 97232

RE: Public Comments on Workplace Violence Prevention Safety Requirements in Healthcare Settings and Administrative Updates

Dear Brittany Hall,

As the State Representative of House District 44, a chief sponsor of Senate Bill 537 and a registered nurse, I am writing to comment on the proposed rules for Workplace Violence Prevention Safety Requirements in Healthcare Settings and Administrative Updates. I would like to thank your staff for their work on the SB 537 Workplace Violence Prevention Safety Requirements in Healthcare Settings Rule Advisory Committee. The process was well organized and allowed for feedback from stakeholders with many differing opinions. My comments on these rules are rooted in the legislative intent behind SB 537 which focused on safety for both patients AND healthcare workers.

Senate Bill 537 was intentionally drafted to improve safety outcomes for both patients and healthcare workers. These goals are not mutually exclusive, and they are deeply interconnected. The Legislature recognized that unsafe care environments compromise not only worker safety, but also care delivery, workforce retention, continuity of care, and ultimately patient outcomes.

This connection is especially evident in home and community-based settings, where clinicians frequently work alone and without the physical infrastructure, security measures, or immediate backup available in acute care environments. For this reason, it is critical that the rulemaking continue to reflect SB 537's dual-safety framework, rather than framing protections for healthcare workers and protections for patients as competing interests.

I understand the hesitation raised by some employers and advocacy organizations regarding concerns about stigma, particularly as it relates to workplace violence. However, improved education and training in trauma-informed care and supportive communication can mitigate stigma while still ensuring that we act now to reduce the incidence and prevalence of workplace violence. Delaying or weakening safety protections in the name of avoiding stigma risks perpetuating harm rather than preventing it.

I would also like to specifically address the clinical realities of home health and hospice care, which is my professional background and an area that has historically been under-supported by legislation and regulation.

In home health and hospice settings, clinicians routinely enter uncontrolled and highly individualized environments. This includes not only the patient's home, but also the surrounding context—parking areas, apartment complexes, rural roads, and city streets. These clinicians do not have access to on-site security, controlled access points, or rapid response teams. As broader social instability and desperation increase, so too does the risk faced by clinicians from patients, family members, and the surrounding community. These risks can result in serious and irreparable harm.

With respect to physical or visual flagging, my advocacy is grounded in prevention. The goal is to provide a just-in-time safety check to address foreseeable clinical risks such as overstimulation, impaired cognition, untreated psychiatric symptoms, substance use, or a known history of aggression. These are clinical facts and not mere moral judgments. From a nursing perspective, advance awareness of these risks enables appropriate care planning, trauma-informed approaches, staffing decisions, and de-escalation strategies. All of these interventions reduce the likelihood of harm for both patients and clinicians.

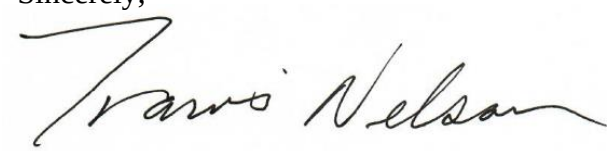
The intent of visual flagging under SB 537 is situational awareness, not labeling or penalizing patients. In time-sensitive or technology-limited environments, discreet visual cues may be the difference between a safe interaction and a dangerous, entirely avoidable escalation. A blanket prohibition on physical or visual flagging in community-based settings would undermine the bill's core principle of meeting people where they are with the supports necessary to keep everyone safe.

It is also important to recognize the equity implications of these decisions. Home health and hospice workers are disproportionately women, people of color, and lower-wage healthcare workers who frequently work alone. Failing to provide meaningful safety protections in the name of avoiding stigma effectively shifts risk onto an already vulnerable workforce, raising serious equity concerns of its own.

For these reasons, I urge the Oregon Health Authority to adopt rules that support clinical judgment, prevention-focused care, and balanced protections for both patients and healthcare workers, rather than creating new barriers to safe practice.

Thank you for the opportunity to comment and for your consideration of these perspectives during the rulemaking process.

Sincerely,



State Representative Travis Nelson RN
House District 44, North/NE Portland

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SECRETARY OF STATE

MICHAEL KAPLAN
DEPUTY SECRETARY OF STATE

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SALEM, OR 97310
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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
11/24/2025 12:08 PM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 333
OREGON HEALTH AUTHORITY
PUBLIC HEALTH DIVISION

FILING CAPTION: Workplace Violence Prevention Safety Requirements in Healthcare Settings and Administrative Updates

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 12/22/2025 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT: Mellony Bernal
971-673-3152
publichealth.rules@odhsoha.oregon.gov

800 NE Oregon St. Suite 465
Portland,OR 97232

Filed By:
Public Health Division
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 12/16/2025
TIME: 10:00 AM
OFFICER: Staff

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 971-277-2343
CONFERENCE ID: 593652434
SPECIAL INSTRUCTIONS:
This hearing is being held remotely via Microsoft Teams. To provide oral (spoken) testimony during this hearing, please contact publichealth.rules@odhsoha.oregon.gov to register to receive the link for the Microsoft Teams video conference via calendar appointment, or you may access the hearing using the meeting URL above. Alternatively, you may dial 971-277-2343, Phone Conference ID 593 652 434# for audio (listen) only. This hearing will close no later than 11:00AM but may close as early as 10:30AM if everyone who signs up to provide testimony has been heard from.

Accessibility Statement: For individuals with disabilities or individuals who speak a language other than English, OHA can provide free help. Some examples are: sign language and spoken language interpreters, real-time captioning, braille, large print, audio, and written materials in other languages. If you need help with these services, please contact the Public Health Division at 971-673-1222, 711 TTY or publichealth.rules@odhsoha.oregon.gov at least 48 hours before the meeting. All relay calls are accepted. To best ensure our ability to provide a modification please contact us if you are considering attending the meeting and require a modification. The earlier you make a request the more likely we can meet the need.

NEED FOR THE RULE(S)

The Oregon Health Authority, Public Health Division, Health Care Regulation and Quality Improvement section is amending and adopting administrative rules in OAR chapter 333, divisions 027, 035, 071, 500, 505 and 535 in response to the passage of SB 537 (2025 OL ch. 535, §9, 12-13). This legislation requires specific health care settings to implement policies and procedures relating to workplace violence prevention safety requirements including identifying and assessing possible health and safety-related risks that staff may encounter, provide workplace training, conduct safety assessments, implement client identification processes, create safety check-in processes, and implement the use of visual flagging and electronic health record flagging for purposes of identifying persons that may pose a potential threat or who have disruptive behavior.

Additional changes include removing outdated language and allowing greater flexibility for a home health agency to serve a larger service area when serving a historically underserved population. Also, in alignment with hospital rules, proposed changes require a home health agency, hospice program or special inpatient care facility (SICF) to conduct an equity analysis of populations that may be impacted by a request to waive an administrative rule and provide steps to mitigate possible impacts to disproportionately affected populations. Due to passage of SB 965 (2023 Oregon Laws, ch. 199), confidentiality provisions were added for filing a complaint about a hospice program, and procedures clarified for employees reporting possible violations of rules.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

- SB 537 (2025): https://olis.oregonlegislature.gov/liz/2025R1/Measures/Analysis/SB537
- SB 965 (2023): https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2023orlaw0199.pdf
- Centers for Medicare and Medicaid Services (CMS), State Operations Manual, Appendix M - Hospice: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf
- Oregon Crisis Care Guidance: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le-589101.pdf

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STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

Workplace violence in the healthcare industry accounted for a rate of 14 nonfatal injuries involving days aways from work per 10,000 full-time equivalences; more than triple the overall rate for all industries combined. While healthcare workers make up 10% of the workforce, they experience 48% of the nonfatal injuries due to workplace violence (CDC, 2024).

Violence in the home care setting is an increasing problem as home care workers provide services to millions of people who need assistance. Per an article from the CDC, home health care workers are largely female, non-white, and among the lowest paid in healthcare. In 2020, workers in the home health care service industry were reported to be 88% female, 29% Black or African American, and 19% Latino or Hispanic. The median annual pay for home health and personal care aides in 2020 was $27,080/year and $13.02/hour. The article further noted that scientific studies have linked violence in home healthcare settings to negative emotional, cognitive, behavioral, physical, and psychosocial outcomes among workers. The adverse effects of violence can severely impact the delivery of healthcare services and the quality of care, and can result in diminished productivity, job dissatisfaction, drug and alcohol use, and poor health outcomes among workers.

In a report published by the American Hospital Association assessing the financial costs and other impacts of workplace violence in hospitals and the health system (The Burden of Violence to U.S. Hospital), it was noted that workplace violence can be associated with employee absenteeism, loss of productivity, and turnover and the annual costs exceed $541 million. Additionally, it was noted that beyond the financial burden, there are many other costs of violence. Health care workers who experience or witness violence can experience many psychological impacts that affect their well-being as well as impact the health system. These psychological impacts lead to reduced workplace satisfaction and

productivity, and recruitment and retention challenges, further impacting the burden of violence to hospitals. Patient and healthcare worker safety are intrinsically linked. Recent research has found that in most instances, a positive patient safety culture was associated with lower workplace violence and workforce burnout scores (CDC, 2024).

SB 537 and corresponding proposed administrative rules seek to bolster workplace violence prevention programs by increasing training requirements and implementing systems to protect both employees and patients, thereby reducing instances of workplace violence in hospitals and home care settings which would ultimately benefit underserved communities by way of retaining qualified healthcare providers. Such improvements may lead to less turnover, and as such, the retention of diverse staff.

Concerns were expressed during the Rule Advisory Committee that the act of flagging an individual is stigmatizing and discriminatory by nature, often disproportionately impacting people of color and people with disabilities. Based on an article from the Journal of the American Medical Association, use of flagging systems routinely results in systematic racial disparities in how flags are applied, with Black patients being flagged twice as often as white patients, longer wait times experienced, less likely to undergo laboratory testing and imaging, and more likely to be discharged or leave against medical advice prior to completion of treatment. (JAMA Network). Visual flags for home health care settings are stigmatizing by nature as the definition implies that a visual flag must be posted on the premises of a patient's own home or residence, or to require a person wear a stigmatizing wristband or other item in the privacy of their own home. Publicly labeling people as dangerous could threaten a person's wellbeing, their housing, and their dignity. The regulations do not propose a time frame for removing flags; as such, flags could remain in place for many years, leaving patients, particularly in rural areas, subject to possible discrimination.

The legislation and the rules provide for necessary training for persons assigning flags to be aware of potentially stigmatizing effects and implicit bias, and language has been added to ensure that training includes instruction on reducing unconscious bias to ensure that flags are not unfairly or disproportionately applied to groups subjected to historical and contemporary discrimination. Furthermore, the intent of the legislation and the rules is to not permanently flag an individual. The proposed administrative rules require that flags be reviewed every 12 months to determine whether flags should be removed or maintained. Additionally, the administrative rules clarify that visual flags, when used, must communicate essential information in a clear, respectful, and non-stigmatizing manner to promote safety and provide neutral alerts or reminders that guide appropriate action without assigning negative labels or implying violence. Agencies and facilities will be required to review procedures and protocols on an annual basis to ensure that flagging practices are fair, respectful, bias-free, and up to date – protecting individuals from stigma while ensuring safety and effective communication.

Additionally, these rules have been amended to allow a Home Health Agency greater flexibility in serving a larger service area if serving a historically underserved population. A Home Health Agency's geographical service area is limited to 60 miles; however, the revised rules will allow an agency to request a waiver from this requirement if the agency proposes to provide home health services to an underserved area or population of the state and can adequately demonstrate the agency's ability to manage and control the services provided. Rules relating to waivers have also been revised to require Home Health Agencies, Hospice Programs and Special Inpatient Care Facilities to conduct an analysis of the possible impact a waiver, if granted, would have on persons from different backgrounds and cultures, including but not limited to persons of color, persons with disabilities, persons with lower incomes, and the LGBTQ2S+ community. The goal of these changes is to ensure that waiver decisions take into account the potential impact on historically underserved or marginalized groups. By requiring this analysis, the rules aim to reduce health disparities and promote more equitable care.

FISCAL AND ECONOMIC IMPACT:

There are currently 63 licensed Home Health Agencies, 75 licensed Hospice Programs and 3 Special Inpatient Care Facilities (SICFs) classified as freestanding hospice facilities that will be required to develop a workplace violence prevention program that includes policy development, intake risk assessments, staff notification requirements, training safety assessments, and safety checks. These agencies will need additional resources such as staff or additional staff time to implement these requirements. Training will need to be developed that meets minimum requirements and must be provided on annual basis. There are a number of private vendors that provide workplace violence prevention training that health care settings may take advantage of, and costs vary significantly from a few hundred dollars for on-line programs available to all staff, to several hundred dollars per person trained.

Home Health Agencies, Hospice Programs, SICFs and Hospitals must implement flagging systems using electronic health record flags and visual flags. It is assumed that hospitals and SICF's currently have electronic health record capabilities; however, these systems may need to be updated to include specific information for flagging purposes. The costs to update necessary programs is unknown but may be costly. Home Health Agencies and Hospice Programs that do not have current electronic systems will need to consider mechanisms that must be implemented which may be costly.

There are currently 64 licensed hospitals in Oregon. Of these, 59 hospitals provide emergency services through an emergency department. Hospitals that seek to renovate or remodel the emergency department will be required to install a bullet-resistant barrier or enclosure at each emergency room intake window. The OHA is unable to provide a cost-analysis for bullet-resistant barriers as construction project costs vary depending on the geographic location of the hospital, the cost of material at the time of construction, the size and scope of the project, the number of stations or windows needing to be upgraded, add-ons, such as a voice port, etc. It is estimated that a single bullet-resistant intake enclosure could cost between $60,000 to $180,000, depending on the complexity of the project, material used, and total square footage of the intake area.

Home Health Agencies, Hospice Programs, and SICFs will be required to conduct an equity analysis of populations that may be impacted by a request to waive an administrative rule as well as provide steps to mitigate possible impacts to disproportionately affected populations. This analysis will require time and staffing resources to complete. Additionally, there may be costs associated with mitigating possible impacts. The impacts on providers are mitigated by the fact that most Home Health Agency and Hospice waiver requests relate to providing services in an expanded area rather than reducing services, so a provider's equity analysis will reflect greater access to care rather than reduced access.

Staff time and resources are anticipated for the development of policies relating to workplace violence prevention safety policy development.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) There are nine hospitals that are operated by special districts that will be impacted by these rule changes: Bay Area Hospital, Blue Mountain Hospital, Coquille Valley Hospital, Curry General Hospital, Harney District Hospital, Lake District Hospital, Lower Umpqua Hospital District, Southern Coos Hospital and Health Center, and Wallowa Memorial Hospital. These hospitals will be required to develop necessary policies and procedures to implement flagging systems. As indicated above, it is assumed that all hospitals currently have electronic health record capabilities, but it is unknown whether these systems may need to be updated to include specific information for flagging purposes. The

costs to update necessary programs is unknown but may be costly.

The OHA, Public Health Division will need to conduct necessary surveys and investigations, including possible enforcement actions if the impacted health care settings fail to comply. The Oregon State Hospital was exempted from the requirements in the bill.

There is no anticipated cost of compliance impact on members of the general public.

(2)(a) The OHA does not collect data on the number of persons employed by Home Health Agencies and Hospice Programs and therefore cannot estimate with accuracy how many of these organizations may be a small business. It is estimated that at least half of these licensed organizations in Oregon may be considered a small business. Hospitals are not considered a small business.

(b) The OHA anticipates that additional staff time and resources will be needed to comply with requirements of establishing a workplace violence prevention program which includes implementing a training program, documentation of staff training, and other administrative requirements.

(c) The OHA anticipates that upgrades to existing software for electronic equipment will be needed and increased supplies may be necessary to comply with the rules.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Participants on the rule advisory committee included representation from home health agencies, hospice programs, and associated professional associations that represent these organizations.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
333-027-0001, 333-027-0046, 333-027-0060, 333-027-0115, 333-027-0125, 333-027-0170, 333-035-0120, 333-035-0125, 333-035-0165, 333-035-0167, 333-035-0220, 333-035-0300, 333-071-0260, 333-071-0400, 333-071-0420, 333-071-0423, 333-071-0425, 333-500-0025, 333-505-0030, 333-505-0036, 333-505-0045, 333-535-0015

AMEND: 333-027-0001

RULE SUMMARY: Amend 333-027-0001: Removes outdated language that no longer applies.

CHANGES TO RULE:

333-027-0001
Compliance with Federal Law
(1) Every ~~H~~home ~~H~~health ~~A~~agency subject to ORS 443.014 to 443.105 must comply with the Conditions of Participation governing home health agencies prescribed by the Centers for Medicare and Medicaid Services (CMS), under 42 CFR Part 484, adopted by reference. ~~A licensed home health agency that is not currently certified by the CMS must ensure that it complies with this rule no later than July 13, 2022.~~¶
(2) Although a naturopathic physician may prescribe services and supplies under a plan of care pursuant to ORS 443.065, those services and supplies ordered by the naturopathic physician are not eligible for reimbursement by CMS.¶
(3) In addition to the requirements of 42 CFR Part 484, home health agencies licensed in Oregon must also comply with the rules in OAR 333-027-0000 through 333-027-0190.
Statutory/Other Authority: ORS 443.085
Statutes/Other Implemented: ORS 443.014 - 443.090

AMEND: 333-027-0046

RULE SUMMARY: Amend 333-027-0046: Amendments to this rule allow greater flexibility for a home health agency to serve a larger service area when serving a historically underserved population.

CHANGES TO RULE:

333-027-0046
Geographic Service Area
(1) As used in this rule, "underserved area or population" means an area in which residents have a shortage of available home health services or a group of persons who face economic, racial, cultural, linguistic, religious, sexual orientation, gender-identity, or age-related barriers to home health services.¶
(2) A home health agency serves a geographic service area that is equal to or less than 60 miles from the physical location of the agency.¶
(~~2~~3) A branch office provides services to the parent agency's location within a portion of the total geographic area served by the parent agency.¶
(~~3~~4) ~~A home health agency that moves its physical location:¶~~
~~(a) Must a~~The Oregon Health Authority (Authority) may permit a home health agency providing care at branch offices, if: ¶
(a) All branch offices are operating under the same Medicare Certification number;¶
(b) All branch offices provide the same level of care and range of care and services offered by the parent home health agency certified by the Centers for Medicare and Medicaid Services (CMS); and ¶
(c) The branch offices are located within a 60-mile radius of the parent home health agency applying for licensure.¶
(5) The Authority may waive the geographical restrictions specified in this rule in accordance with OAR 333-027-0170, including but not limited to, if the parent home health agency proposes to provide home health services to an underserved area or population of the state and adequately demonstrates the ability to manage and control the services. ¶
(6) A home health agency that moves its physical location must:¶
(a) Apply for a new license in accordance with OAR 333-027-0010; and¶
(b) Ensure that the services it provides to patients is within 60 miles from the new physical location.
Statutory/Other Authority: ORS 443.085
Statutes/Other Implemented: ORS 443.075

AMEND: 333-027-0060

RULE SUMMARY: Amend 333-027-0060: The rule is amended to update terms relating to personnel or staff. The rule requires that home health agency employees be notified about the availability of personnel safety training which must be documented in personnel records. The rule further requires a home health agency to establish, and review annually, policies relating to personnel safety requirements and potential threat or disruptive behavior flagging systems.

CHANGES TO RULE:

333-027-0060
Administration of Home Health Agency ¶

(1) An agency shall clearly set forth in writing the organization, services provided, administrative control, and lines of authority for the delegation of responsibility to the patient care level. An agency shall not delegate administrative and supervisory functions to another agency, individual, or organization.¶
(2) An agency shall ensure that:¶
(a) A clinical manager is employed who is responsible for the oversight of all patient care services and personnel and that the clinical manager is available during all operating hours;¶
(b) A professional policy-making committee is established in accordance with ORS 443.065; and¶
(c) All patient complaints are reviewed including documentation and resolution.¶
(3) If an agency chooses to provide professional students with a practicum in home health, the agency must ensure that:¶
(a) A contract between the agency and the accredited educational institution is in effect and includes at a minimum, a description of:¶
(A) Program objectives;¶
(B) Program coordination;¶
(C) Student supervision;¶
(D) Adherence to agency policy; and¶
(E) Conformance with applicable professional practice laws, rules, and regulations.¶
(b) The governing body shall be informed about the contract specified in subsection (3)(a) prior to its implementation.¶
(c) The agency maintains documentation of each practicum and the student's activities, supervision, and the evaluation of these activities.¶
(d) The agency maintains documentation of patient care services provided by the student.¶
(4) An agency's governing body shall assume full legal and fiscal responsibility for the agency's operation. The agency's governing body shall provide for effective communication with administration of the agency and the owner of the agency.¶
(5) An agency's governing body shall:¶
(a) Employ a qualified administrator, unless exempted under ORS 443.025;¶
(b) Regularly monitor the performance of the administrator; and¶
(c) Ensure there is a quality assessment and performance improvement program established and maintained in accordance with OAR 333-027-0160.¶
(6) The administrator shall identify a qualified alternate, designated in writing by the administrator and the governing body to assume responsibilities and obligations of the agency during the administrator's absence. The clinical manager may be designated to serve in this role.¶
(7)(a) The agency shall develop personnel policies which must be appropriate to the agency, be documented, and include:¶
(A) Hours of work;¶
(B) Orientation that is appropriate to the classification of the employee;¶
(C) An inservice program that provides ongoing education to ensure that ~~staff skills~~skills of personnel are maintained for the responsibilities assigned and ensures that ~~staff~~personnel are educated in their responsibility in infection control;¶
(D) Employee notification about the availability of personnel safety training provided in accordance with OAR 333-027-0115;¶
(E) Work performance evaluations;¶
(~~E~~F) Employee health program;¶
(~~F~~G) A tuberculosis infection control plan that includes provisions for employee assessment and screening for protecting patient and employees from tuberculosis in accordance with OAR 333-019-0041; and¶
(~~G~~H) Provisions for the completion of criminal records checks in accordance with ORS 443.004 and OAR 333-

027-0064.¶
(b) Personnel records shall include job descriptions, personnel qualifications, evidence of any required licensure or certification, evidence of orientation and performance evaluations, evidence of a completed criminal records check and fitness determination, and evidence of personnel safety training notification.¶
(8) An agency shall provide health care interpreter services to a patient who prefers to communicate in a language other than English in accordance with ORS 413.559 and OAR 950-050-0160.¶
(9) An agency contracting with individual personnel or public or private entities for home health care services shall maintain written contracts and shall clearly designate:¶
(a) That patients are accepted for care only by the primary agency;¶
(b) The services to be provided;¶
(c) The rights and responsibilities of the contracting individual or entity in the coordination, supervision, and evaluation of the care or service provided;¶
(d) The obligation to comply with all applicable agency policies;¶
(e) The party with responsibility for development and revisions of the plan of care, patient assessment, progress reports, and patient care conferences, scheduling of visits or hours, and discharge planning;¶
(f) Appropriate documentation of services provided on record forms provided by the agency; and¶
(g) The terms of the agreement and basis for renewal or termination.¶
(10) The professional policy-making committee appointed by the agency shall:¶
(a) Be composed of personnel associated with the agency and that meet the requirements in ORS 443.065.¶
(b) Establish in writing and review annually, the agency's policies governing scope of services, admission and discharge policies, personnel safety program requirements in accordance with OAR 333-027-0115, potential threat or disruptive behavior flagging systems in accordance with OAR 333-027-0125, medical supervision, plans of treatment, emergency care, clinical records, personnel qualifications, and quality assessment and performance improvement.¶
(c) Meet as needed to advise the agency on other professional issues.¶
(d) Participate with ~~the agency staff~~personnel in the annual evaluation of the agency's program.¶
(11) The agency shall document the professional-policy making committee's systematic involvement and effective communication with the governing body and the management of the agency.
Statutory/Other Authority: ORS 443.085
Statutes/Other Implemented: ORS 443.014, 443.055, 443.065, 443.085, ~~ORS~~ 413.559, 413.561

ADOPT: 333-027-0115

RULE SUMMARY: Adopt 333-027-0115: New rule is adopted requiring a home health agency to establish, implement, and maintain a workforce violence prevention program. Minimum requirements are specified including information that must be collected, the development and implementation of plan to obtain necessary patient history from a hospital when the patient is referred to receive home health services, keeping personnel apprised of information collected, the provision of annual training on personnel safety, conducting quarterly safety assessments, providing information to verify the identity of a patient, providing a way by which personnel can perform safety checks, and establishing and implementing policies and procedures. Defines terms.

CHANGES TO RULE:

333-027-0115
Personnel Safety Program Requirements
(1) As used in this rule:¶
(a) "Hazards" means potentially unsafe or dangerous conditions in or around the home health care setting, including but not limited to the presence of uncontrolled animals, persistent or periodic presence of individuals with history of aggressive behavior or substance use disorder, elevated rate of criminal activity, poor or unreliable cell phone coverage, and lack of timely law enforcement or emergency response capability.¶
(b) "Home health care setting" means a place of temporary or permanent residence of an individual where home health care services are furnished to the individual. ¶
(c) "Safety check" means the process by which personnel can access, review, and apply safety-related information collected by the agency in accordance with this rule, and includes a mechanism for personnel to directly contact the agency to report safety concerns.¶
(2) An agency shall establish, implement, and maintain a workforce violence prevention program that includes, but is not limited to, the following requirements:¶
(a) Intake risk assessment. An agency must collect information necessary to identify and assess health and safety-related risks and hazards in a home health care setting, including but not limited to:¶
(A) Any act or threat of physical violence, harassment, intimidation, assault, homicide or any other threatening behavior where home health care services are provided to a patient;¶
(B) Presence of pet(s) and if any, whether the pet(s) can be secured away from the area where care is provided, if requested by personnel;¶
(C) Possible pest infestations, for example, rodents or insects; and ¶
(D) Whether the patient is willing to securely store any weapons that are present in the home health care setting before any visit from personnel.¶
(b) Hospital discharge coordination. When a patient is discharged from a hospital and referred to an agency, the agency must develop and implement a plan to obtain any known patient history of violence within the last 12 months from the hospital as part of continuity of care.¶
(c) Personnel notification. The agency must have a protocol, and implement the protocol, to share all information collected under subsections (2)(a) and (b) of this rule with personnel assigned to provide home health care services to the patient.¶
(d) Training. An agency shall provide annual training on personnel safety. The training must be consistent with training for home health care workers endorsed by the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration and must include the following: ¶
(A) Recognizing hazards that are commonly found by personnel where home health care services are provided to a patient; and¶
(B) How to manage hazards that are identified.¶
(C) This training may be incorporated as part of the mandated requirements under ORS 654.414(4). ¶
(e) Quarterly safety assessments. An agency must conduct quarterly safety assessments with personnel who have been assigned to provide home health care services. A safety assessment may consist of the same criteria required under ORS 654.414(2) and (3).¶
(f) Patient identification. An agency must provide personnel with information that may be used to verify the identity of a patient prior to an initial home health care visit. ¶
(g) Safety checks. An agency must provide a mechanism by which personnel can perform safety checks, including but not limited to use of a mobile application to access relevant safety-related information identified under subsections (2)(a) and (b) of this rule, use of communication devices that allow personnel to transmit one-way or two-way messages, or regular check-ins. ¶
(h) Policy development. An agency shall establish and implement policies and procedures that allow personnel

to:¶
(A) Perform data entry and chart updates at a time and place outside the location where home health care services are provided; and¶
(B) Be accompanied by an escort, including but not limited to another employee, when there are concerns about the safety or security of the setting where home health care services are provided to the patient.
Statutory/Other Authority: ORS 413.042, ORS 443.085
Statutes/Other Implemented: ORS 443.065, ORS 443.085, 2025 OL ch. 535 §12-13

ADOPT: 333-027-0125

RULE SUMMARY: Adopt 333-027-0125: New rule requires a home health agency to develop and implement protocols and procedures for implementing and using a flagging system to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals. Clarifies that the flagging system includes both electronic health record (EHR) flags and visual flags. Requires that visual flags, when used, be clear, respectful, and non-stigmatizing to promote safety and provide neutral alerts. Specifies minimum criteria for EHR flags and visual flags. Requires that EHR flags be reviewed annually and updated as determined necessary. Prescribes that home health agency personnel may not take certain actions based solely on the fact that a person has been flagged. Defines terms.

CHANGES TO RULE:

333-027-0125
Potential Threat or Disruptive Behavior Flagging Systems
(1) As used in this rule: ¶
(a) "Authorized staff" means the personnel who are responsible for creating and tracking electronic health record flags.¶
(b) "Disruptive behavior" includes physically aggressive, harassing, or destructive behavior. ¶
(c) "Electronic health record (EHR) flag" means an alert generated within the electronic health record of a patient that notifies providers that a patient may pose a potential safety risk to themselves or to others due to the patient's history of violent or disruptive behavior.¶
(d) "Flagging system" means a system used to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals, including caregivers or support persons, who may encounter health care providers and personnel. ¶
(e) "Visual flags" means paper-based physical cues, including wristbands, signage, color-coded indicators, symbols and other visible cues built within the care environment to facilitate immediate recognition of potential threats of violence or disruptive behavior without having to access an electronic health record. Visual flags, when used, must communicate essential information in a clear, respectful, and non-stigmatizing manner to promote safety and provide neutral alerts or reminders that guide appropriate action without assigning negative labels or implying violence. ¶
(2) An agency shall implement flagging systems with the capabilities and functions to communicate potential threats of violence or disruptive behavior to providers and personnel using EHR flags and visual flags. ¶
(3) Each agency must establish and implement written protocols and procedures for implementing and using flagging systems. The flagging system must address, at a minimum, the following:¶
(a) Criteria and process for initiating flags, continuing flags, inactivating flags, and reactivating EHR flags and visual flags. ¶
(b) Requirements for new and revised EHR flags and visual flags that include: ¶
(A) The reasons for initiating or revising the flag; and¶
(B) Specific recommended actions that agency providers and personnel should take when interacting with a flagged individual.¶
(c) For EHR flags:¶
(A) Designating authorized staff to initiate an EHR flag.¶
(B) Training and education requirements for personnel authorized to initiate an EHR flag, including training on identifying and preventing bias in the assignment of such flags, and instruction on reducing unconscious bias to ensure that EHR flags are not unfairly or disproportionately applied to individuals belonging to groups subjected to historical and contemporary discrimination.¶
(C) Provider and personnel responsibilities when an EHR flag is present.¶
(D) Evaluating and identifying potential threats of violence or disruptive behavior.¶
(E) Consistent practices for assigning, tracking, monitoring, and documenting information in the EHR flag.¶
(F) Reviewing EHR flags every 12 months at a minimum, and updating EHR flags, as necessary, for purposes of determining whether to remove or maintain a flag.¶
(G) Communication and collaboration about flagged conduct or behaviors recorded in an EHR.¶
(H) Safety protocols and precautions for engaging with patients with an EHR flag. ¶
(I) Patient privacy in relation to personnel safety, including compliance with state and federal privacy laws when communicating information through the electronic health record regarding an EHR flag.¶
(J) Requiring that every flag-related action, including but not limited to initiation or reactivation, be supported by documentation for the action.¶
(K) Establishing a process by which a patient, or a person authorized to make health care decisions on behalf of the

patient, such as a caregiver or support person, may request review and removal of an EHR flag.¶
(d) For visual flags, education and training for authorized staff on:¶
(A) Identifying circumstances and assessing behaviors and actions of patients and other individuals that may increase risk for potential violence or disruptive behavior;¶
(B) Consistent approaches to initiating a visual flag; and¶
(C) Safety protocols and precautions to take when encountering patients or other individuals when a visual flag is present.¶
(4) Providers and personnel of an agency may not take any of the following actions based solely on the presence of an EHR flag:¶
(a) Deny home health services to which the patient would otherwise be eligible.¶
(b) Make decisions regarding the patient's access to care.¶
(c) Prevent or restrict the right of the patient to file a complaint with the appropriate federal or state agency concerning the patient's right to privacy.¶
(d) Deny or restrict the patient's right to access or obtain the patient's protected health information.¶
(e) Contact, report or disclose information to law enforcement, unless it is necessary to prevent or lessen serious or imminent threat to the health or safety of an employee, patient, caregiver, support person, or the public.¶
(f) Deny, restrict or withhold medical or nonmedical care that is appropriate for the patient.¶
(g) Punish or penalize the patient.
Statutory/Other Authority: ORS 413.042, ORS 443.085
Statutes/Other Implemented: ORS 443.065, ORS 443.085, 2025 OL ch. 535 §9

AMEND: 333-027-0170

RULE SUMMARY: Amend 333-027-0170: The rule is amended to require additional information when a home health agency is requesting a waiver from an administrative rule requirement. The request for a waiver must include information on the possible impacts to persons with different backgrounds and cultures, persons with limited English proficiency, households with lower incomes, and persons based on their gender identity and sexual orientation. The facility would also need to specify how the impact was determined and what would be proposed steps to mitigate the impact on disproportionately affected populations.

CHANGES TO RULE:

333-027-0170
Waivers ¶

(1) While all agencies are required to maintain continuous compliance with these rules, these requirements do not prohibit the use of alternative concepts, methods, procedures, techniques, equipment, facilities, personnel qualifications or the conducting of pilot projects or research. A request for a waiver from a rule must~~:¶~~
~~(a) B~~ be submitted to the ~~Authority in writing;~~Oregon Health Authority (Authority) in writing and include the following information:¶
(~~b~~a) Identif~~y~~ication of the specific rule for which a waiver is requested;¶
(~~c~~b) ~~Identify t~~The special circumstances relied upon to justify the waiver;¶
(~~d) Explain why the agency is unable to be in compliance, w~~c) What alternatives were considered, if any, and why alternatives (including compliance) were not selected;¶
(~~e~~d) ~~D~~Information demonstrate~~e~~ing that the proposed waiver is desirable to maintain or improve the health and safety of the patients, to meet the individual and aggregate needs of patients, and will not jeopardize patient health and safety; ~~and~~¶
(e) For an initial waiver request received on or after [insert effective date of this rule] or any request received on or after [insert effective date of this rule] to renew a waiver, a description of the following:¶
(~~f~~A) ~~Include t~~Possible impacts that the proposed waiver may have on persons from different backgrounds and cultures, including but not limited to individuals of color, individuals with disabilities, individuals with limited English proficiency, people or households with lower incomes, and individuals who identify as lesbian, gay, bisexual, transgender, queer, two-spirit, intersex, asexual, nonbinary, or another minority gender identity or another sexual orientation;¶
(B) How the impact was determined; and¶
(C) Proposed steps to mitigate the impact on disproportionately affected populations; and¶
(f) The proposed duration of the waiver.¶
(2) Upon finding that the agency has satisfied the conditions of this rule, the Authority may grant ~~the~~a waiver.~~.~~¶
(3) An agency may not implement a waiver until it has received written approval from the Authority.¶
(4) During an emergency the Authority may waive a rule that an agency is unable to meet, for reasons beyond the agency's control. If the Authority waives a rule under this section, it shall issue an order, in writing, specifying which rules are waived, which agencies are subject to the order, and how long the order shall remain in effect.
Statutory/Other Authority: ORS 443.085
Statutes/Other Implemented: ORS 443.085

AMEND: 333-035-0120

RULE SUMMARY: Amend 333-035-0120: Amends the definition of 'Patient Family Unit' in an effort to align language used in the definition of hospice program and language used by the Centers for Medicare and Medicaid Services, Conditions of Participation by referencing "medical prognosis”.

CHANGES TO RULE:

333-035-0120
Definitions ¶

As used in OAR chapter 333, division 35, the following definitions apply:¶
(1) "Accreditation" means a designation by an accrediting organization that a hospice program has met standards that have been developed to indicate a quality program.¶
(2) "Administrator" means a hospice employee responsible for the administrative functions and day-to-day operations of the hospice program.¶
(3) "Authority" means the Oregon Health Authority, Public Health Division. ¶
(4) "CMS" means Centers for Medicare and Medicaid Services.¶
(5) "Certification" means a state agency's official recommendations and findings to CMS regarding a hospice program's compliance with federal CMS regulations.¶
(6) "Conditions of Participation" mean the applicable federal regulations that hospice programs are required to comply with to participate in the federal Medicare and Medicaid programs.¶
(7) "Hospice aide" means a person:¶
(a) Certified by the Oregon State Board of Nursing as a certified nursing assistant (CNA) under ORS 678.442; ¶
(b) Who has successfully completed a training program and competency evaluation in accordance with 42 CFR 418.76(a); or¶
(c) Who has successfully completed a competency evaluation in accordance with 42 CFR 418.76(c). ¶
(8) "Hospice program" means a coordinated program of home and inpatient care, available 24 hours a day, that utilizes an interdisciplinary team of personnel trained to provide palliative and supportive services to a patient-family unit experiencing a life-threatening disease with a limited medical prognosis. A hospice program is an institution for purposes of ORS 146.100.¶
(9) "Hospice services" means items and services provided to a patient-family unit by a hospice program or by other individuals or community agencies under a consulting or contractual arrangement with a hospice program. Hospice services include home care, inpatient care for acute pain and symptom management or respite, and bereavement services provided to meet the physical, psychosocial, emotional, spiritual and other special needs of a patient-family unit during the final stages of illness, dying and the bereavement period.¶
(10)(a) "Interdisciplinary team" means a group of individuals working together in a coordinated manner to provide hospice care. An interdisciplinary team includes, but is not limited to, the patient-family unit, the patient's attending physician or clinician and one or more of the following hospice program personnel who are trained and experienced to provide hospice care:¶
(A) Physician;¶
(B) Physician associate;¶
(C) Nurse practitioner;¶
(D) Nurse;¶
(E) Nurse's aide or hospice aide;¶
(F) Occupational therapist;¶
(G) Physical therapist;¶
(H) Trained lay volunteer;¶
(I) Clergy or spiritual counselor; ¶
(J) Credentialed mental health professional such as psychiatrist, psychologist, psychiatric nurse or social worker; or¶
(K) Naturopathic physician.¶
(b) The interdisciplinary team is not the same as the interdisciplinary group as that term is defined under 42 CFR 418.56; however, interdisciplinary team members may be included in the interdisciplinary group meetings. The purpose of the interdisciplinary team is to include the patient, patient's family, and the patient's attending physician or clinician when formulating a plan of care to ensure that the full range of needs of the patient and family are met. ¶
(11) "Medicare Certification Number" means the unique identification number, also referred to as the Medicare Provider Number, assigned to a qualifying hospice program by CMS.¶

(12) "Nurse's aide" means a CNA certified by the Oregon State Board of Nursing under ORS 678.442.¶
(13) "Palliative care" has the meaning given that term in ORS 413.273. ¶
(14) "Parent hospice program" means the program that provides supervision and administrative control to multiple locations providing care that are within a 60-mile radius from the parent hospice program's physical location.¶
(15) "Patient-family unit" includes an individual who has a life-threatening disease with a limited medical prognosis and all others sharing housing, common ancestry or a common personal commitment with the individual.¶
(16) "Person" includes individuals, organizations and groups of organizations.¶
(17) "Survey" means an inspection of an applicant for a hospice program license or a hospice program to determine the extent to which the applicant or hospice program is in compliance with state hospice program statutes, these rules and CMS Conditions of Participation.¶
(18) "These rules" means OAR 333-035-0110 through 333-035-0300.
Statutory/Other Authority: ORS 443.860
Statutes/Other Implemented: ORS 443.850, 443.867

AMEND: 333-035-0125

RULE SUMMARY: Amend 333-035-0125: The rule is amended by removing vague language relating to 'sufficient staff' and clarifies that a hospice program needs to have documentation that demonstrates it maintains a workforce capable of meeting the demands of hospice services.

CHANGES TO RULE:

333-035-0125
Application for Licensure and Fees ¶

(1) A person may not establish, conduct or maintain a hospice program providing hospice services, or hold itself out to the public as a hospice program, without obtaining a license from the ~~Authority.~~ Oregon Health Authority (Authority).¶
(2)(a) A person applying for a new or renewal license to operate a hospice program shall submit a complete application on a form prescribed by the Authority, accompanied by the fee specified in ORS 443.860.¶
(b) A complete application for an initial license includes, but is not limited to:¶
(A) Documentation of written policies and procedures, including any forms and curricula to direct all administrative, personnel, and patient care operations;¶
(B) Documentation that patient care and documentation systems have been developed; and¶
(C) Documentation ~~that sufficient,~~demonstrating that the hospice program maintains a workforce of qualified~~,~~ and trained employees or contractors ~~are available to provide~~capable of meeting hospice service~~s and that~~ demands, with personnel records ~~have been prepar~~properly establish~~ed~~ for each employee or contractor.¶
(3) The Authority may deem an application incomplete if it does not include the information required by the Authority, is not accompanied by the appropriate fee, or at the time of initial survey fails to comply with subsection (2)(b) of this rule.¶
(4) The Authority may reject an application that is incomplete.¶
(5)(a) Within 30 days of the change, a hospice program must inform the Authority in writing of any change in:¶
(A) Ownership;¶
(B) Ownership category (for example, corporation, partnership, sole proprietorship);¶
(C) Administrator;¶
(D) Business name;¶
(E) Medicare certification number;¶
(F) Primary and multiple locations;¶
(G) Physical location; or¶
(H) Mailing address.¶
(b) If ownership of a hospice program changes, the hospice program must submit a new license application indicating change of ownership along with the required fee.¶
(c) If a parent hospice program moves 30 miles or more from its current physical location, the parent hospice program must apply for a new license and pay the required fee.¶
(6) The Authority may issue a civil penalty for failure to timely notify the Authority of any changes under section (5) of this rule or suspend, revoke or deny the license.¶
(7) A hospice program may provide palliative care in addition to hospice services as defined in these rules. A hospice program providing palliative care is not subject to licensure as an in-home care agency under ORS 443.867.¶
(8) A hospice program licensed in a bordering state must be licensed in Oregon to provide care to patients located in Oregon. The hospice program must apply and be licensed in accordance with these rules. The hospice program is subject to these rules including, the geographic service area restrictions specified in OAR 333-035-0160.¶
(9) A hospice program license is nontransferable.¶
(10) Licensure fees are not prorated and are non-refundable.
Statutory/Other Authority: ORS 443.860
Statutes/Other Implemented: ORS 443.860, 443.867

ADOPT: 333-035-0165

RULE SUMMARY: Adopt 333-035-0165: New rule is adopted requiring a hospice program to establish, implement, and maintain a workforce violence prevention program. Minimum requirements are specified including information that must be collected, the development and implementation of plan to obtain necessary patient history from a hospital when the patient is referred to receive home health services, keeping personnel apprised of information collected, the provision of annual training on personnel safety, conducting quarterly safety assessments, providing information to verify the identity of a patient, providing a way by which personnel can perform safety checks, and establishing and implementing policies and procedures. Policies and procedures must be reviewed annually. The rule further requires that hospice program employees be notified about the availability of personnel safety training which must be documented in personnel records. Defines terms.

CHANGES TO RULE:

333-035-0165
Personnel Safety Program Requirements
(1) As used in this rule:¶
(a) "Hazards" means potentially unsafe or dangerous conditions in or around the home health care setting, including but not limited to the presence of uncontrolled animals, persistent or periodic presence of individuals with history of aggressive behavior or substance use disorder, elevated rate of criminal activity, poor or unreliable cell phone coverage, and lack of timely law enforcement or emergency response capability.¶
(b) "Home health care setting" means a place of temporary or permanent residence of an individual where hospice services are furnished to the individual.¶
(c) "Safety check" means the process by which personnel can access, review, and apply safety-related information collected by the agency in accordance with this rule, and includes a mechanism for personnel to directly contact the agency to report safety concerns.¶
(2) A hospice program shall establish, implement, and maintain a workforce violence prevention program that includes, but is not limited to, the following requirements:¶
(a) Intake risk assessment. A hospice program must collect information necessary to identify and assess health and safety-related risks and hazards in a home health care setting, including but not limited to:¶
(A) Any act or threat of physical violence, harassment, intimidation, assault, homicide or any other threatening behavior where hospice services are provided to a patient;¶
(B) Presence of pet(s) and if any, whether the pet(s) can be secured away from the area where care is provided, if requested by personnel;¶
(C) Possible pest infestations, for example, rodents or insects; and¶
(D) Whether the patient is willing to securely store any weapons that are present in the home health care setting before any visit from personnel. ¶
(b) Hospital discharge coordination. When a patient is discharged from a hospital and referred to a hospice program, the hospice program must develop and implement a plan to obtain any known patient history of violence within the last 12 months from the hospital as part of continuity of care.¶
(c) Personnel notification. The hospice program must have a protocol, and implement the protocol, to share all information collected under subsections (2)(a) and (b) of this rule with personnel assigned to provide hospice services to the patient.¶
(d) Training. A hospice program shall provide annual training on personnel safety. The training must be consistent with training for home health care workers endorsed by the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration and must include the following: ¶
(A) Recognizing hazards that are commonly found by personnel where hospice services are provided to a patient; and¶
(B) How to manage hazards that are identified.¶
(C) This training may be incorporated as part of the mandated requirements under ORS 654.414(4).¶
(e) Quarterly safety assessments. A hospice program must conduct quarterly safety assessments with personnel who have been assigned to provide hospice services. A safety assessment may consist of the same criteria required under ORS 654.414(2) and (3).¶
(f) Patient identification. A hospice program must provide personnel with information that may be used to verify the identity of a patient prior to an initial hospice visit. ¶
(g) Safety checks. A hospice program must provide a mechanism by which personnel can perform safety checks, including but not limited to use of a mobile application to access relevant safety-related information identified under subsections (2)(a) and (b) of this rules, use of communication devices that allow the employee to transmit

one-way or two-way messages, or regular check-ins. ¶
(h) Policy development. A hospice program shall establish in writing and implement policy and procedures on personnel safety program requirements. The policy and procedures must be reviewed annually and include at a minimum: ¶
(A) Allowing personnel to perform data entry and chart updates at a time and place outside the location where hospice services are provided; ¶
(B) Allowing personnel to be accompanied by an escort, including but not limited to another employee, when there are concerns about the safety or security of the setting where hospice services are provided to the patient; ¶
(C) Employee notification about the availability of personnel safety training provided in accordance with subsection (2)(d) of this rule; and¶
(D) Documenting in personnel records evidence of personnel safety training notification.
Statutory/Other Authority: ORS 413.042, ORS 443.860
Statutes/Other Implemented: ORS 443.860, 2025 OL ch. 535 §12-13

ADOPT: 333-035-0167

RULE SUMMARY: Adopt 333-035-0167: New rule requires a hospice program to develop and implement protocols and procedures for implementing and using a flagging system to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals. Clarifies that the flagging system includes both electronic health record (EHR) flags and visual flags. Requires that visual flags, when used, be clear, respectful, and non-stigmatizing to promote safety and provide neutral alerts. Specifies minimum criteria for EHR flags and visual flags. Requires that EHR flags be reviewed annually and updated as determined necessary. Prescribes that hospice program personnel may not take certain actions based solely on the fact that a person has been flagged. Defines terms.

CHANGES TO RULE:

333-035-0167
Potential Threat or Disruptive Behavior Flagging Systems
(1) As used in this rule: ¶
(a) "Authorized staff" means the personnel who are responsible for creating and tracking electronic health record flags.¶
(b) "Disruptive behavior" includes physically aggressive, harassing, or destructive behavior. ¶
(c) "Electronic health record (EHR) flag" means an alert generated within the electronic health record of a patient that notifies providers that a patient may pose a potential safety risk to themselves or to others due to the patient's history of violent or disruptive behavior.¶
(d) "Flagging system" means a system used to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals, including caregivers or support persons, who may encounter health care providers and personnel. ¶
(e) "Visual flags" means paper-based physical cues, including wristbands, signage, color-coded indicators, symbols and other visible cues built within the care environment to facilitate immediate recognition of potential threats of violence or disruptive behavior without having to access an electronic health record. Visual flags, when used, must communicate essential information in a clear, respectful, and non-stigmatizing manner to promote safety and provide neutral alerts or reminders that guide appropriate action without assigning negative labels or implying violence. ¶
(2) A hospice program shall implement flagging systems with the capabilities and functions to communicate potential threats of violence or disruptive behavior to providers and personnel using EHR flags and visual flags. ¶
(3) Each hospice program must establish and implement written protocols and procedures for implementing and using flagging systems. The flagging systems must address, at a minimum, the following: ¶
(a) Criteria and process for initiating flags, continuing flags, inactivating flags, and reactivating EHR flags and visual flags. ¶
(b) Requirements for new and revised EHR flags and visual flags that include: ¶
(A) The reasons for initiating or revising the flag; and¶
(B) Specific recommended actions that agency providers and personnel should take when interacting with a flagged individual.¶
(c) For EHR flags:¶
(A) Designating authorized staff to initiate an EHR flag.¶
(B) Training and education requirements for personnel authorized to initiate an EHR flag, including training on identifying and preventing bias in the assignment of such flags, and instruction on reducing unconscious bias to ensure that EHR flags are not unfairly or disproportionately applied to individuals belonging to groups subjected to historical and contemporary discrimination.¶
(C) Provider and personnel responsibilities when an EHR flag is present.¶
(D) Evaluating and identifying potential threats of violence or disruptive behavior.¶
(E) Consistent practices for assigning, tracking, monitoring, and documenting information in the EHR flag.¶
(F) Reviewing EHR flags every 12 months at a minimum and updating EHR flags, as necessary, for purposes of determining whether to remove or maintain a flag.¶
(G) Communication and collaboration about flagged conduct or behaviors recorded in an EHR.¶
(H) Safety protocols and precautions for engaging with patients with an EHR flag. ¶
(I) Patient privacy in relation to personnel safety, including compliance with state and federal privacy laws when communicating information through the electronic health record regarding an EHR flag.¶
(J) Requiring that every flag-related action, including but not limited to initiation or reactivation, be supported by documentation for the action.¶
(K) Establishing a process by which a patient, or a person authorized to make health care decisions on behalf of the

patient, such as a caregiver or support person, may request review and removal of an EHR flag.¶
(d) For visual flags, education and training for authorized staff on:¶
(A) Identifying circumstances and assessing behaviors and actions of patients and other individuals that may increase risk for potential violence or disruptive behavior;¶
(B) Consistent approaches to initiating a visual flag; and¶
(C) Safety protocols and precautions to take when encountering patients or other individuals when a visual flag is present.¶
(4) Providers and personnel of a hospice program may not take any of the following actions based solely on the presence of an EHR flag:¶
(a) Deny hospice services to which the patient would otherwise be eligible.¶
(b) Make decisions regarding the patient's access to care.¶
(c) Prevent or restrict the right of the patient to file a complaint with the appropriate federal or state agency concerning the patient's right to privacy.¶
(d) Deny or restrict the patient's right to access or obtain the patient's protected health information.¶
(e) Contact, report or disclose information to law enforcement, unless it is necessary to prevent or lessen serious or imminent threat to the health and safety of an employee, patient, caregiver, support person, or the public.¶
(f) Deny, restrict or withhold medical or nonmedical care that is appropriate for the patient.¶
(g) Punish or penalize the patient.¶
(5) Written protocols and procedures must be established pursuant to section (3) of this rule and be reviewed annually.
Statutory/Other Authority: ORS 413.042, ORS 443.860
Statutes/Other Implemented: ORS 443.860, 2025 OL ch. 535 §9

AMEND: 333-035-0220

RULE SUMMARY: Amend 333-035-0220: This rule has been amended due to the passage of SB 965 (2023), clarifying the confidentiality provisions for persons making a complaint and the procedures for employees reporting possible violations of rules.

CHANGES TO RULE:

333-035-0220
Complaints ¶

(1) Any person may make a complaint verbally or in writing to the ~~Authority~~Oregon Health Authority (Authority) regarding an allegation as to the care or services provided by a hospice program or violations of any hospice program laws or regulations.¶
(2) The ~~Authority may investigate after receipt of a complaint in accordance with OAR 333-035-0230.¶~~
~~(3~~identity of a person making a complaint and any personally identifiable information, as that is defined in ORS 432.005 is confidential and not subject to disclosure under ORS 192.311 to 192.478.¶
(3) The Authority may investigate after receipt of a complaint in accordance with OAR 333-035-0230.¶
(4) An employee or contract provider with knowledge of a violation of ORS chapter 443 or these rules, shall use the reporting procedures established by the hospice program before notifying the Authority or other state agency of the inappropriate care or violation, unless the employee or contract provider:¶
(a) Believes a patient's health or safety is in immediate jeopardy; or¶
(b) Files a complaint in accordance with section (1) of this rule.¶
(5) If the complaint involves an allegation of criminal conduct or an allegation that is within the jurisdiction of another local, state, or federal agency, the Authority may refer the matter to that agency.
Statutory/Other Authority: ORS 443.860, ORS 443.013
Statutes/Other Implemented: ORS 443.860, ORS 443.013

AMEND: 333-035-0300

RULE SUMMARY: Amend 333-035-0300: The rule is amended to require additional information when a hospice program is requesting a waiver from an administrative rule requirement. The request for a waiver must include information on the possible impacts to persons with different backgrounds and cultures, persons with limited English proficiency, households with lower incomes, and persons based on their gender identity and sexual orientation. The facility would also need to specify how the impact was determined and what would be proposed steps to mitigate the impact on disproportionately affected populations.

CHANGES TO RULE:

333-035-0300
Waivers
(1) While all hospice programs are required to maintain continuous compliance with these rules, these requirements do not prohibit the use of alternative concepts, methods, procedures, techniques, equipment, facilities, personnel qualifications or the conducting of pilot projects or research. A request for a waiver from a rule must~~:~~¶
~~(a) B~~ be submitted to the ~~Authority in writing;~~Oregon Health Authority (Authority) in writing and include the following information:¶
(~~b~~a) Identif~~y~~ication of the specific rule for which a waiver is requested;¶
(~~c~~b) ~~Identify t~~The special circumstances relied upon to justify the waiver;¶
(~~d~~c) ~~Explain why the hospice program is unable to comply, w~~What alternatives were considered, if any, and why alternatives (including compliance) were not selected;¶
(~~e~~d) ~~D~~Information demonstrat~~e~~ing that the proposed waiver is desirable to maintain or improve the health and safety of the patients, to meet the individual and aggregate needs of patients, and will not jeopardize patient health and safety; ~~and~~¶
~~(f) Include t~~¶
(e) For an initial waiver request received on or after [insert effective date of rules] or any request received on or after [insert effective date of rules] to renew a waiver, a description of the following:¶
(A) Possible impacts that the proposed waiver may have on persons from different backgrounds and cultures, including but not limited to individuals of color, individuals with disabilities, individuals with limited English proficiency, people or households with lower incomes, and individuals who identify as lesbian, gay, bisexual, transgender, queer, two-spirit, intersex, asexual, nonbinary, or another minority gender identity or another sexual orientation;¶
(B) How the impact was determined; and¶
(C) Proposed steps to mitigate the impact on disproportionately affected populations; and¶
(f) The proposed duration of the waiver.¶
(2) Upon finding that the hospice program has satisfied the conditions of this rule, the Authority may grant a waiver.¶
(3) A hospice program may not implement a waiver until it has received written approval from the Authority.¶
(4) During an emergency the Authority may waive a rule that a hospice program is unable to meet, for reasons beyond the hospice program's control. If the Authority waives a rule under this section, it shall issue an order, in writing, specifying which rules are waived, which hospice programs are subject to the order, and how long the order shall remain in effect.
Statutory/Other Authority: ORS 443.860
Statutes/Other Implemented: ORS 443.860

AMEND: 333-071-0260

RULE SUMMARY: Amend 333-071-0260: The rule is amended to require additional information when a special inpatient care facility is requesting a waiver from an administrative rule requirement. The request for a waiver must include information on the possible impacts to persons with different backgrounds and cultures, persons with limited English proficiency, households with lower incomes, and persons based on their gender identity and sexual orientation. The facility would also need to specify how the impact was determined and what would be proposed steps to mitigate the impact on disproportionately affected populations.

CHANGES TO RULE:

333-071-0260
Waivers ¶

(1) While all special inpatient care facilities (SICFs) are required to maintain continuous compliance with the ~~Authority's~~Oregon Health Authority's (Authority) rules, these requirements do not prohibit the use of alternative concepts, methods, procedures, techniques, equipment, facilities, personnel qualifications or the conducting of pilot projects or research. A request for a waiver from a rule must be~~:~~ ¶
~~(a) S~~ submitted to the Authority in writing~~;~~ and include the following information:¶
(~~b~~a) Identif~~y~~ication of the specific rule for which a waiver is requested;~~.~~¶
(~~c~~b) The special circumstances relied upon to justify the waiver;~~.~~¶
(~~d~~c) What alternatives were considered, if any, and why alternatives (including compliance) were not selected;~~.~~¶
(~~e~~d) ~~D~~Information d~~e~~monstrat~~e~~ing that the proposed waiver is desirable to maintain or improve the health and safety of the patients, and will not jeopardize patient health and safety; ~~and~~ ¶
(e) For an initial waiver request received on or after [insert effective date of rules] or any request received on or after [insert effective date of rules] to renew a waiver, a description of the following:¶
(~~f~~A) ~~The proposed duration of the exception.~~ Possible impacts that the proposed waiver may have on persons from different backgrounds and cultures, including but not limited to individuals of color, individuals with disabilities, individuals with limited English proficiency, people or households with lower incomes, and individuals who identify as lesbian, gay, bisexual, transgender, queer, two-spirit, intersex, asexual, nonbinary, or another minority gender identity or another sexual orientation;¶
(B) How the impact was determined; and¶
(C) Proposed steps to mitigate the impact on disproportionately affected populations; and¶
(f) The proposed duration of the waiver.¶
(2) Upon finding that the SICF has satisfied the conditions of this rule, the Authority may grant a waiver.~~.~~¶
(3) An SICF may not implement a waiver until it has received written approval from the Authority.~~.~~¶
(4) During an emergency, the Authority may waive a rule that an SICF is unable to meet, for reasons beyond the SICF's control. If the Authority waives a rule under this section, it shall issue an order, in writing, specifying which rules are waived, which SICFs are subject to the order, and how long the order will remain in effect.
Statutory/Other Authority: ORS 441.025
Statutes/Other Implemented: ORS 441.025

AMEND: 333-071-0400

RULE SUMMARY: Amend 333-071-0400: The rule makes clarifying changes to rule text. The rule further requires that a special inpatient care facility is required to develop and implement policies and procedures relating to potential threats of violence and disruptive behavior flagging systems that must be reviewed annually. The rule also requires freestanding hospice facilities to develop and implement a personnel safety program that meets specified requirements and that must be reviewed annually.

CHANGES TO RULE:

333-071-0400
Organization Policies
(1) A special inpatient care facility's (SICF's) internal organization shall be structured to include appropriate departments and services consistent with the needs of its defined community.¶
(2) An SICF shall adopt and maintain clearly written definitions of its organization, authority, responsibility, relationships and scope of services offered.¶
(3) An SICF shall adopt, maintain and follow written ~~patient care~~ policies that include but are not limited to:¶
(a) ~~A~~Patient admission and transfer policies that address:¶
(A) Types of clinical conditions not acceptable for patient admission;¶
(B) Constraints imposed by limitations of services, staff coverage or physical facilities. No patient shall be admitted to a bed in any room, other than one regularly designated as a bedroom or ward;¶
(C) Emergency patient admissions;¶
(D) Requirements for informed consent signed by the patient or legal representative of the patient for diagnostic and treatment procedures; such policies and procedures shall address informed consent of minors in accordance with provisions in ORS 109.640, 109.670, and 109.675;¶
(E) Requirements for identifying persons responsible for obtaining informed consent and other appropriate disclosures and ensuring that the information provided is accurate and documented appropriately in accordance with these rules and ORS 441.098; and¶
(F) A process for the internal transfer of patients from one level or type of care to another, if applicable;¶
(b) ~~D~~Patient discharge planning and termination of services in accordance with OAR 333-505-0055;¶
(c) Patient rights;¶
(d) Housekeeping;¶
(e) All patient care services provided by the facility;¶
(f) Preventive maintenance program for all aspects of the facility's physical plant, operations, and equipment used in patient care and patient environment;¶
(g) Treatment or referral of acute sexual assault patients in accordance with ORS 147.403;~~.~~¶
(h) Identification of patients who could benefit from palliative care in order to provide information and facilitate access to appropriate palliative care in accordance with ORS 413.273; ~~and~~¶
(i) Procedures for ensuring that an SICF provides health care interpreter services to a patient who prefers to communicate in a language other than English in accordance with ORS 413.559 and OAR 950-050-0160;¶
(j) In accordance with OAR 333-071-0425, protocols and procedures for implementing and using potential threats of violence and disruptive behavior flagging systems. These protocols and procedures must be reviewed on an annual basis; and¶
(k) For an SICF classified as a freestanding hospice facility, personnel safety program requirements in accordance with OAR 333-071-0423. These requirements must be reviewed on an annual basis. ¶
(4) In addition to the policies described in section (3) of this rule, an SICF shall, in accordance with the Patient Self-Determination Act, 42 CFR 489.102, adopt policies and procedures that require (applicable to all capable individuals 18 years of age or older who are receiving health care in the facility):¶
(a) Providing to each adult patient, including emancipated minors, not later than five days after an individual is admitted as an inpatient, but in any event before discharge, the following in written form, without recommendation:¶
(A) Information on the rights of the individual under Oregon law to make health care decisions, including the right to accept or refuse medical treatment and the right to execute directives and powers of attorney for health care;¶
(B) Information on the policies of the facility with respect to the implementation of the rights of the individual under Oregon law to make health care decisions;¶
(C) A copy of the advance directive form set forth in ORS 127.529; ~~and~~¶
(D) The name of a person who can provide additional information concerning the forms for directives~~.~~;¶
(b) Documenting in a prominent place in the individual's medical record whether the individual has executed a directive~~.~~;¶

(c) Compliance with ORS chapter 127 relating to directives for health care.; and¶
(d) Educating the staff and the community on issues relating to directives.¶
(5) An SICF's transfer agreements or contracts shall clearly delineate the responsibilities of parties involved.¶
(6) Patient care policies shall be evaluated triennially and rewritten as needed, and presented to the governing body or a designated administrative body for approval triennially. Documentation of the evaluation is required.¶
(7) An SICF shall have a system, described in writing, for the periodic evaluation of programs and services, including contracted services.
Statutory/Other Authority: ORS 441.025
Statutes/Other Implemented: ORS 147.401, 413.273, 441.025, 441.196, 441.198, 413.559, 413.56113.559, 413.561, 441.051, 441.054

AMEND: 333-071-0420

RULE SUMMARY: Amend 333-071-0420: Vague terms have been removed and clarified by stating that a special inpatient care facility must maintain a workforce that meets service demands. Additionally, language has been added stating that a freestanding hospice facility must notify all personnel of the availability of personnel safety training that must be documented in personnel records.

CHANGES TO RULE:

333-071-0420
Personnel ¶

(1) A~~n~~ special inpatient care facility (SICF) shall:¶
(a) Maintain a ~~sufficient number of qualified personnel~~workforce of qualified and trained personnel capable of meeting the service demands of the SICF, and equipment to provide effective patient care and all other related services;~~-~~¶
(b) Have written personnel policies and procedures that are available to personnel;~~-~~¶
(c) Provide orientation for new employees;~~-~~¶
(d) Have an annual continuing education plan;~~-~~¶
(e) Have a job description for each position which delineates the qualifications, duties, authority and responsibilities inherent in each position;~~-~~¶
(f) Provide an annual work performance evaluation for each employee with appropriate records maintained; and¶
(g) Have an employee health screening program for the purpose of protecting patients and employees from communicable diseases, including but not limited to requiring tuberculosis testing for employees in accordance with OAR 333-071-0450.~~-~~¶
(2) In addition to the requirements specified in section (1) of this rule, an SICF classified as a rehabilitation hospital shall ~~have~~:¶
(a) ~~A~~Have a medical director with training or experience in rehabilitation who provides services in the facility for a minimum of 20 hours per week;¶
(b) ~~A sufficient number~~Maintain a workforce of qualified physical therapists, occupational therapists, speech-language pathologists or audiologists based on the rehabilitative services offered~~;¶~~
~~(c) An adequate number~~ capable of meeting service demands;¶
(c) Maintain a workforce of qualified ~~staff~~personnel available when needed to evaluate each patient, initiate a plan of treatment and supervise supportive personnel when furnishing rehabilitation services. The number of qualified ~~staff~~personnel is based on the type of patients treated and the frequency, duration and complexity of the treatment ordered; and¶
(d) An individual that directs the rehabilitation services offered that has the necessary knowledge, experience and capabilities to properly supervise and administer the services.¶
(3) In addition to the requirements specified in section (1) of this rule, an SICF classified as a freestanding hospice facility shall notify all personnel about the availability of personnel safety training provided in accordance with OAR 333-071-0423 and document notification in personnel records. ¶
(4) An SICF shall restrict the work of employees with restrictable diseases in accordance with OAR 333-019-0010.¶
(45) The actions taken by an SICF under this rule shall be fully documented for each employee.
Statutory/Other Authority: ORS 441.025, ~~ORS~~ 431.110, 433.004, 433.332
Statutes/Other Implemented: ORS 441.025, ORS 433.004, 433.329, 2025 OL ch. 535 §12-13

ADOPT: 333-071-0423

RULE SUMMARY: Adopt 333-071-0423: New rule is adopted requiring a freestanding hospice facility to establish, implement, and maintain a workforce violence prevention program. Minimum requirements are specified including information that must be collected, the development and implementation of plan to obtain necessary patient history from a hospital when the patient is referred to receive home health services, keeping personnel apprised of information collected, the provision of annual training on personnel safety, conducting quarterly safety assessments, providing information to verify the identity of a patient, providing a way by which personnel can perform safety checks, and establishing and implementing policies and procedures.

CHANGES TO RULE:

333-071-0423
Personnel Safety Program Requirements
(1) As used in this rule:¶
(a) "Hazards" means potentially unsafe or dangerous conditions in or around the home health care setting, including but not limited to the presence of uncontrolled animals, persistent or periodic presence of individuals with history of aggressive behavior or substance use disorder, elevated rate of criminal activity, poor or unreliable cell phone coverage, and lack of timely law enforcement or emergency response capability.¶
(b) "Home health care setting" means a place of temporary or permanent residence of an individual where hospice services are furnished to the individual.¶
(c) "Safety check" means the process by which personnel can access, review, and apply safety-related information collected by the agency in accordance with this rule, and includes a mechanism for personnel to directly contact the agency to report safety concerns.¶
(2) A special inpatient care facility (SICF) classified as a freestanding hospice facility shall establish, implement, and maintain a workforce violence prevention program that includes, but is not limited to, the following requirements:¶
(a) Intake risk assessment. The freestanding hospice facility must collect information necessary to identify and assess health and safety-related risks and hazards in a home health care setting, including but not limited to:¶
(A) Any act or threat of physical violence, harassment, intimidation, assault, homicide or any other threatening behavior where hospice services are provided to a patient;¶
(B) Presence of pet(s) and if any, whether the pet(s) can be secured away from the area where care is provided, if requested by personnel;¶
(C) Possible pest infestations, for example, rodents or insects; and¶
(D) Whether the patient is willing to securely store any weapons that are present in the home health care setting before any visit from hospice personnel. ¶
(b) Hospital discharge coordination. When a patient is discharged from a hospital and referred to a freestanding hospice facility, the facility must develop and implement a plan to obtain any known patient history of violence within the last 12 months from the hospital as part of continuity of care.¶
(c) Personnel notification. The freestanding hospice facility must have a protocol, and implement the protocol, to share all information collected under subsections (2)(a) and (b) of this rule with personnel assigned to provide hospice services to the patient.¶
(d) Training. The freestanding hospice facility shall provide annual training on personnel safety. The training must be consistent with training for home health care workers endorsed by the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration and must include the following: ¶
(A) Recognizing hazards that are commonly found by personnel where hospice services are provided to a patient; and¶
(B) How to manage hazards that are identified.¶
(C) This training may be incorporated as part of the mandated requirements under ORS 654.414(4).¶
(e) Quarterly safety assessments. A freestanding hospice facility must conduct quarterly safety assessments with personnel who have been assigned to provide hospice services. A safety assessment may consist of the same criteria required under ORS 654.414(2) and (3). ¶
(f) Patient identification. A freestanding hospice facility must provide personnel with information that may be used to verify the identity of a patient prior to an initial hospice visit. ¶
(g) Safety checks. A freestanding hospice facility must provide a mechanism by which personnel can perform safety checks, including but not limited to use of a mobile application to access relevant safety-related information identified under subsections (2)(a) and (b) of this rule, use of communication devices that allow personnel to transmit one-way or two-way messages, or regular check-ins. ¶

(h) Policy development. A freestanding hospice facility shall establish in writing and implement policy and procedures that allow personnel to: ¶
(A) Perform data entry and chart updates at a time and place outside the location where hospice services are provided; and¶
(B) Be accompanied by an escort, including but not limited to another employee, when there are concerns about the safety or security of the setting where hospice services are provided to the patient.
Statutory/Other Authority: ORS 413.042, ORS 441.025, ORS 443.860
Statutes/Other Implemented: ORS 441.025, ORS 443.860, ORS 442.015, 2025 OL ch. 535 §12-13

ADOPT: 333-071-0425

RULE SUMMARY: Adopt 333-071-0425: New rule requires a special inpatient care facility to develop and implement protocols and procedures for implementing and using a flagging system to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals. Clarifies that the flagging system includes both electronic health record (EHR) flags and visual flags. Requires that visual flags, when used, be clear, respectful, and non-stigmatizing to promote safety and provide neutral alerts. Specifies minimum criteria for EHR flags and visual flags. Requires that EHR flags be reviewed annually and updated as determined necessary. Prescribes that personnel may not take certain actions based solely on the fact that a person has been flagged. Defines terms.

CHANGES TO RULE:

333-071-0425
Potential Threat or Disruptive Behavior Flagging Systems
(1) As used in this rule: ¶
(a) "Authorized staff" means the personnel who are responsible for creating and tracking electronic health record flags.¶
(b) "Disruptive behavior" includes physically aggressive, harassing, or destructive behavior. ¶
(c) "Electronic health record (EHR) flag" means an alert generated within the electronic health record of a patient that notifies providers that a patient may pose a potential safety risk to themselves or to others due to the patient's history of violent or disruptive behavior.¶
(d) "Flagging system" means a system used to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals, including caregivers or support persons, who may encounter health care providers and personnel. ¶
(e) "Visual flags" means paper-based physical cues, including wristbands, signage, color-coded indicators, symbols and other visible cues built within the care environment to facilitate immediate recognition of potential threats of violence or disruptive behavior without having to access an electronic health record. Visual flags, when used, must communicate essential information in a clear, respectful, and non-stigmatizing manner to promote safety and provide neutral alerts or reminders that guide appropriate action without assigning negative labels or implying violence. ¶
(2) A special inpatient care facility (SICF) shall implement flagging systems with the capabilities and functions to communicate potential threats of violence or disruptive behavior to providers and personnel using EHR flags and visual flags. ¶
(3) An SICF must establish and implement written protocols and procedures for implementing and using flagging systems. The flagging system must address, at a minimum, the following:¶
(a) Criteria and process for initiating flags, continuing flags, inactivating flags, and reactivating EHR flags and visual flags. ¶
(b) Requirements for new and revised EHR flags and visual flags that include: ¶
(A) The reasons for initiating or revising the flag; and¶
(B) Specific recommended actions that agency providers and personnel should take when interacting with a flagged individual.¶
(c) For EHR flags:¶
(A) Designating authorized staff to initiate an EHR flag.¶
(B) Training and education requirements for personnel authorized to initiate an EHR flag, including training on identifying and preventing bias in the assignment of such flags, and instruction on reducing unconscious bias to ensure that EHR flags are not unfairly or disproportionately applied to individuals belonging to groups subjected to historical and contemporary discrimination.¶
(C) Provider and personnel responsibilities when an EHR flag is present.¶
(D) Evaluating and identifying potential threats of violence or disruptive behavior.¶
(E) Consistent practices for assigning, tracking, monitoring, and documenting information in the EHR flag.¶
(F) Reviewing EHR flags every 12 months at a minimum and updating EHR flags, as necessary, for purposes of determining whether to remove or maintain a flag.¶
(G) Communication and collaboration about flagged conduct or behaviors recorded in an EHR.¶
(H) Safety protocols and precautions for engaging with patients with an EHR flag. ¶
(I) Patient privacy in relation to personnel safety, including compliance with state and federal privacy laws when communicating information through the electronic health record regarding an EHR flag.¶
(J) Requiring that every flag-related action, including but not limited to initiation or reactivation, be supported by documentation for the action.¶

(K) Establishing a process by which a patient, or a person authorized to make health care decisions on behalf of the patient, such as a caregiver or support person, may request review and removal of an EHR flag.¶
(d) For visual flags, education and training for authorized staff on:¶
(A) Identifying circumstances and assessing behaviors and actions of patients and other individuals that may increase risk for potential violence or disruptive behavior;¶
(B) Consistent approaches to initiating a visual flag; and¶
(C) Safety protocols and precautions to take when encountering patients or other individuals when a visual flag is present.¶
(4) Providers and personnel of an SICF may not take any of the following actions based solely on the presence of an EHR flag:¶
(a) Deny services to which the patient would otherwise be eligible.¶
(b) Make decisions regarding the patient's access to care.¶
(c) Prevent or restrict the right of the patient to file a complaint with the appropriate federal or state agency concerning the patient's right to privacy.¶
(d) Deny or restrict the patient's right to access or obtain the patient's protected health information.¶
(e) Contact, report or disclose information to law enforcement, unless it is necessary to prevent or lessen serious or imminent threat to the health or safety of an employee, patient, caregiver, support person, or the public.¶
(f) Deny, restrict or withhold medical or nonmedical care that is appropriate for the patient.¶
(g) Punish or penalize the patient.
Statutory/Other Authority: ORS 413.042, ORS 441.025
Statutes/Other Implemented: ORS 441.025, ORS 441.020, 2025 OL ch. 535 §9

AMEND: 333-500-0025

RULE SUMMARY: Amend 333-500-0025: Specifies that a satellite of a hospital must comply with the potential threat or disruptive behavior flagging systems.

CHANGES TO RULE:

333-500-0025
~~I~~Endorsement of Satellite Operations ¶

(1) The Oregon Health Authority (Authority) may ~~i~~endorse, under a hospital's license, a satellite or mobile satellite of a hospital.¶
(2) In order for a satellite to be ~~i~~endorsed under a hospital's license, the applicant or licensee shall pay the appropriate fee and provide evidence to the Authority that:¶
(a) The satellite meets the requirements in OAR chapter 333, divisions 500 through 535;¶
(b) The services at the satellite are integrated with the hospital;¶
(c) The financial operations of the satellite are integrated with the hospital;¶
(d) The hospital and the satellite have the same governing body;¶
(e) The satellite is under the ownership and control of the hospital;¶
(f) Staff at the satellite have privileges at the hospital;¶
(g) Medical records of the satellite are integrated with the hospital into a unified system;¶
(h) The satellite is in compliance with OAR 333-505-0045 relating to potential threat or disruptive behavior flagging systems;¶
(i) The facility is not subject to certificate of need requirements in ORS 442.315 to 442.347; and¶
(~~i~~j) If the satellite is intended to provide emergency medical services, the satellite can comply with OAR 333-500-0027.¶
(3) A hospital applying for an emergency medical services satellite ~~i~~endorsement must also submit for its emergency department, the information described in OAR 333-500-0027(1)(e), for the previous six months.¶
(4) A satellite shall be subject to a plans review and must pass life safety code requirements.¶
(5) In order for a mobile satellite to be ~~i~~endorsed under a hospital's license, the applicant or licensee shall pay the appropriate fee and provide evidence to the Authority that:¶
(a) The mobile satellite is operated in whole or in part by the hospital through lease, ownership or other arrangement;¶
(b) The services at the mobile satellite are integrated with the hospital;¶
(c) The financial operations of the mobile satellite are integrated with the hospital;¶
(d) The mobile satellite is physically separate from the hospital and other buildings on the hospital campus by at least 20 feet; and¶
(e) It meets the 2000 NFPA 101 Life Safety Code for mobile units.¶
(6) A mobile satellite shall keep and provide to the Authority and the Fire Marshal upon request, a log that shows where the mobile satellite is located every day of the year, and its use. A copy of the log shall be kept in the mobile satellite at all times.¶
(7) A hospital that has a satellite that provides inpatient services that is ~~i~~endorsed under its license as of October 1, 2009, may continue to have that satellite ~~i~~endorsed under its license. On or after October 1, 2009, a satellite must meet the definition of satellite in OAR 333-500-0010(46) and comply with all other rules related to satellites in order to have a satellite ~~i~~endorsed under a hospital license.¶
(8) Nothing in these rules is meant to:¶
(a) Prevent a satellite as defined in OAR 333-500-0010(46) from providing outpatient medical services; or¶
(b) Permit the ~~i~~endorsement of satellite under a hospital license as a means to circumvent the certificate of need laws in ORS ~~C~~chapter 442 and OAR chapter 333, divisions 545 through 670.¶
(9) The Authority may revoke the ~~i~~endorsement of a satellite at any time if it determines a hospital or its satellite:¶
(a) Is not complying with this rule or OAR 333-500-0027, as applicable; or¶
(b) Is unable to ensure the safety of patients at the satellite.
Statutory/Other Authority: ORS 441.025, ORS 413.042
Statutes/Other Implemented: ORS 441.020

AMEND: 333-505-0030

RULE SUMMARY: Amend 333-505-0030: Text has been added requiring a hospital to develop necessary policies and procedures that includes a plan to share with home health agencies or hospice programs any known patient history of violence within the last 12 months, when a patient has been referred to receive home health or hospice services. Specifies that the hospital must also adopt and maintain protocols and procedures for implementing and using a potential threat or disruptive behavior flagging system that must be reviewed on an annual basis. Minor change was also made to align the meaning of the term POLST with OAR chapter 333, division 270.

CHANGES TO RULE:

333-505-0030
Organization, Hospital Policies ¶

(1) A hospital's internal organization shall be structured to include appropriate departments and services consistent with the needs of its defined community.¶
(2) A hospital shall adopt and maintain clearly written definitions of its organization, authority, responsibility and relationships.¶
(3) A hospital shall adopt, maintain and follow written patient care policies that include but are not limited to:¶
(a) Admission and transfer policies that address:¶
(A) Types of clinical conditions not acceptable for admission;¶
(B) Constraints imposed by limitations of services, physical facilities or staff coverage;¶
(C) Emergency admissions;¶
(D) Requirements for informed consent signed by the patient or legal representative of the patient for diagnostic and treatment procedures; such policies and procedures shall address informed consent of minors in accordance with provisions in ORS 109.640, 109.670, and 109.675;¶
(E) Requirements for identifying persons responsible for obtaining informed consent and other appropriate disclosures and ensuring that the information provided is accurate and documented appropriately in accordance with these rules and ORS 441.098; ~~and~~¶
(F) A process for the internal transfer of patients from one level or type of care to another; and¶
(G) A plan to share with home health or hospice agencies any known patient history of violence within the last 12 months, when a patient is referred to receive home health or hospice services; ¶
(b) Discharge, termination of services, and release from emergency department policies in accordance with OAR 333-505-0055 and OAR 333-520-0070;¶
(c) Patient rights, including but not limited to compliance with OAR 333-505-0033;¶
(d) Housekeeping;¶
(e) Mandatory use of identification badges for health care practitioners providing direct patient care which must include the practitioner's name and professional title in accordance with ORS 441.096. The policy must also identify the size of badges to be used;¶
(f) All patient care services provided by the hospital;¶
(g) Maintenance of the hospital's physical plant, equipment used in patient care and patient environment;¶
(h) Treatment or referral of acute sexual assault patients in accordance with ORS 147.403; and¶
(i) Identification of patients who could benefit from palliative care in order to provide information and facilitate access to appropriate palliative care in accordance with ORS 413.273.¶
(4) In addition to the policies described in section (3) of this rule, a hospital shall~~,~~ ~~i~~:¶
(a) In accordance with 42 CFR 489.102, ORS 127.649, and ORS 127.652, adopt and maintain written policies and procedures concerning a patient's right to accept or refuse medical or surgical treatment and the right to formulate an advance directive or appoint a health care representative; and¶
(b) In accordance with OAR 333-505-0045, adopt and maintain protocols and procedures for implementing and using potential threat or disruptive flagging systems. These protocols and procedures must be reviewed on an annual basis.¶
(5) A hospital may not condition the provision of treatment on a patient having a physician order or portable order for life-sustaining treatment (POLST) as that term is defined in OAR chapter 333, division 270 and ORS 127.663, an advance directive as defined in ORS 127.505, a form appointing a health care representative under ORS 127.510, or any instruction relating to the administration, withholding or withdrawing of life-sustaining procedures or artificially administered nutrition and hydration.¶
(6) A hospital's transfer agreements or contracts shall clearly delineate the responsibilities of parties involved.¶
(7) Patient care policies shall be evaluated triennially and rewritten as needed and presented to the governing

body or a designated administrative body for approval triennially. Documentation of the evaluation is required.¶
(8) A hospital shall have a system, described in writing, for the periodic evaluation of programs and services, including contracted services.
Statutory/Other Authority: ORS 441.025, ORS 413.042
Statutes/Other Implemented: ORS 413.273, ORS 441.025, ORS 441.051, ORS 441.054, ORS 441.048, ORS 441.096, 2025 OL ch. 535 §9

AMEND: 333-505-0036

RULE SUMMARY: Amend 333-505-0036: Makes minor changes to text to align with language used in the Oregon Crisis Care Guidance and makes a minor change to text to align the meaning of the term POLST with OAR chapter 333, division 270.

CHANGES TO RULE:

333-505-0036
Hospital Requirements During Emergency Impacting Standard of Care
(1) This rule does not circumvent or supersede Centers for Medicare and Medicaid Services (CMS) requirements to meet the needs of the facility and care of patients.¶
(2) For purposes of this rule:¶
(a) "Crisis standards of care" means policies or standards adopted by a hospital to be implemented during an emergency to make triage decisions, such as but not limited to Oregon Health Authority (Authority) adopted crisis standards of care and related tools.¶
(b) "Emergency" includes but is not limited to a federal emergency declaration, Governor's declared emergency, a determination by the state Public Health Director under ORS 431A.015(1), an epidemic as that is defined in ORS 431A.005, or any other unforeseen event that results in an increased need for scarce hospital resources or a significant reduction of health care staff.¶
(c) "Hospital" has the meaning given that term in ORS 442.015, but does not include a Special Inpatient Care Facility as that term is defined under OAR 333-071-0205.¶
(d) "Support person" has the meaning given that term in OAR 333-505-0033.¶
(e) "Triage decisions" means the decisions necessary to provide equitable prioritization of critical care resources for patients during an emergency.¶
(3) When a hospital is making triage decisions because of an emergency the hospital must:¶
(a) Within 24 hours provide notice to the ~~Oregon Health~~ Authority at mailbox.hclc@odhsoha.oregon.gov, or in another manner as directed by the Authority.¶
(b) Within 24 hours inform the public by at a minimum posting information on its website and at the hospital in multiple conspicuous locations that the hospital is making triage decisions because of an emergency. The information must be posted in the five most common spoken languages in the county where the hospital is located. This information is accessible on the Secretary of State's website: https://www.oregon.gov/languages/Pages/common-language-county.aspx.¶
(c) Post the crisis standard of care the hospital is using to make triage decisions on its website in the five most common spoken languages in the county where the hospital is located.¶
(d) For each patient that is subject to a triage decision, communicate the outcome of the triage decision to the patient, their support person, or the individual legally authorized to act on behalf of the patient, in an accessible format, language they understand and in a culturally responsive manner to the extent possible, including how the triage decision was made, and immediately provide a copy of the crisis standard of care used to make the triage decision.¶
(e) Document for each patient that is subject to a triage decision:¶
(A) The patient's medical record number.¶
(B) The hospital's name and location.¶
(C) The patient's date of birth.¶
(D) The patient's ~~sexual orientation and gender identity, if known.¶~~
~~(E) The patient's race, ethnicity,~~race, ethnicity, preferred spoken or signed language and preferred written language ~~and~~, disability, sexual orientation and gender identity in accordance with OAR chapter 950, division 30.¶
(~~F~~E) Whether, at the time of presentation at the hospital, the patient was using a personal ventilator or other personal medical treatment equipment or resources.¶
(~~G~~F) The patient's home address, whether they are unhoused, or whether their housing status is unknown.¶
(~~H~~G) The patient's care preferences, as documented in an advanced directive, physician order or portable order~~s~~ for life-sustaining treatment (POLST), or as communicated by a health care representative, support person, or a family member.¶
(~~I~~H) The patient's triage prioritization and clinical outcome.¶
(4) A hospital must provide the documentation required in section (3) of this rule to the Authority upon request.¶
Note: The Oregon Health Authority's Interim Crises Care Tool can be found at www.healthoregon.org/hflc.
Statutory/Other Authority: ORS 413.042, ORS 441.025
Statutes/Other Implemented: ORS 441.025

ADOPT: 333-505-0045

RULE SUMMARY: Adopt 333-505-0045: New rule requires a hospital to develop and implement protocols and procedures for implementing and using a flagging system to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals. Clarifies that the flagging system includes both electronic health record (EHR) flags and visual flags. Requires that visual flags, when used, be clear, respectful, and non-stigmatizing to promote safety and provide neutral alerts. Specifies minimum criteria for EHR flags and visual flags. Requires that EHR flags be reviewed annually and updated as determined necessary. Prescribes that hospital personnel may not take certain actions based solely on the fact that a person has been flagged. Defines terms.

CHANGES TO RULE:

333-505-0045
Potential Threat or Disruptive Behavior Flagging Systems
(1) As used in this rule: ¶
(a) "Authorized staff" means the personnel who are responsible for creating and tracking electronic health record flags.¶
(b) "Disruptive behavior" includes physically aggressive, harassing, or destructive behavior. ¶
(c) "Electronic health record (EHR) flag" means an alert generated within the electronic health record of a patient that notifies providers that a patient may pose a potential safety risk to themselves or to others due to the patient's history of violent or disruptive behavior.¶
(d) "Flagging system" means a system used to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals, including caregivers or support persons, who may encounter health care providers and personnel. ¶
(e) "Visual flags" means paper-based physical cues, including wristbands, signage, color-coded indicators, symbols and other visible cues built within the care environment to facilitate immediate recognition of potential threats of violence or disruptive behavior without having to access an electronic health record. Visual flags, when used, must communicate essential information in a clear, respectful, and non-stigmatizing manner to promote safety and provide neutral alerts or reminders that guide appropriate action without assigning negative labels or implying violence. ¶
(2) A hospital shall implement flagging systems with the capabilities and functions to communicate potential threats of violence or disruptive behavior to providers and personnel using EHR flags and visual flags. ¶
(3) Each hospital must establish and implement written protocols and procedures for implementing and using flagging systems. The flagging system must address, at a minimum, the following:¶
(a) Criteria and process for initiating flags, continuing flags, inactivating flags, and reactivating EHR flags and visual flags. ¶
(b) Requirements for new and revised EHR flags and visual flags that include: ¶
(A) The reasons for initiating or revising the flag; and¶
(B) Specific recommended actions that hospital providers and personnel should take when interacting with a flagged individual.¶
(c) For EHR flags:¶
(A) Designating authorized staff to initiate an EHR flag.¶
(B) Training and education requirements for personnel authorized to initiate an EHR flag, including training on identifying and preventing bias in the assignment of such flags, and instruction on reducing unconscious bias to ensure that EHR flags are not unfairly or disproportionately applied to individuals belonging to groups subjected to historical and contemporary discrimination.¶
(C) Provider and personnel responsibilities when an EHR flag is present.¶
(D) Evaluating and identifying potential threats of violence or disruptive behavior.¶
(E) Consistent practices for assigning, tracking, monitoring, and documenting information in the EHR flag.¶
(F) Reviewing EHR flags every 12 months at a minimum and updating EHR flags, as necessary, for purposes of determining whether to remove or maintain a flag.¶
(G) Communication and collaboration about flagged conduct or behaviors recorded in an EHR.¶
(H) Safety protocols and precautions for engaging with patients with an EHR flag. ¶
(I) Patient privacy in relation to personnel safety, including compliance with state and federal privacy laws when communicating information through the electronic health record regarding an EHR flag.¶
(J) Requiring that every flag-related action, including but not limited to initiation or reactivation, be supported by documentation for the action.¶
(K) Establishing a process by which a patient, or a person authorized to make health care decisions on behalf of the

patient, such as a caregiver or support person, may request review and removal of an EHR flag.¶
(d) For visual flags, education and training for authorized staff on:¶
(A) Identifying circumstances and assessing behaviors and actions of patients and other individuals that may increase risk for potential violence or disruptive behavior;¶
(B) Consistent approaches to initiating a visual flag; and¶
(C) Safety protocols and precautions to take when encountering patients or other individuals when a visual flag is present.¶
(4) Providers and personnel of a hospital may not take any of the following actions based solely on the presence of an EHR flag:¶
(a) Deny services to which the patient would otherwise be eligible.¶
(b) Make decisions regarding the patient's access to care.¶
(c) Prevent or restrict the right of the patient to file a complaint with the appropriate federal or state agency concerning the patient's right to privacy.¶
(d) Deny or restrict the patient's right to access or obtain the patient's protected health information.¶
(e) Contact, report or disclose information to law enforcement, unless it is necessary to prevent or lessen serious or imminent threat to the health or safety of an employee, patient, caregiver, support person, or the public.¶
(f) Deny, restrict or withhold medical or nonmedical care that is appropriate for the patient.¶
(g) Punish or penalize the patient.
Statutory/Other Authority: ORS 413.042, ORS 441.025
Statutes/Other Implemented: ORS 441.025, ORS 441.020, 2025 OL ch. 535 §9

AMEND: 333-535-0015

RULE SUMMARY: Amend 333-535-0015: Adds a requirement that hospitals undergoing new construction or when a hospital is altering or renovating the emergency department, it must install a bullet-resistant intake area where patients are registered. Minimum construction elements are specified.

CHANGES TO RULE:

333-535-0015
Physical Environment
(1) Any person proposing to construct a new hospital, or proposing to make certain alterations or additions to an existing hospital, must, before commencing new construction, alterations, or additions, comply with OAR chapter 333, division 675 and these rules. ¶
(2) Only the portion of an existing hospital that is being altered or renovated and any impacted ancillary areas required to ensure full functionality of the hospital must meet the requirements in sections (3) through (7) of this rule. ¶
(3) An applicant or a licensed hospital must comply with the 2018, Facility Guidelines Institute (FGI), Guidelines for Design and Construction of Hospitals, and the 2018, FGI, Guidelines for Design and Construction of Outpatient Facilities, adopted by reference, including all references to part, subpart, sections, subsections, paragraphs, subparagraphs and appendices except as specified in sections (4) through (7) of this rule. References in FGI to "and/or" mean "or."¶
(4) The following chapters, sections, paragraphs, subparagraphs or appendices of the 2018, FGI, Guidelines for Design and Construction of Hospitals are deleted in their entirety:¶
(a) Subsection A.1.2-2.1.2.1;¶
(b) Subsection 1.2-2.1.2.3;¶
(c) Section 1.2-8;¶
(d) Section 1.2-9;¶
(e) Paragraph (2)(b) in subsection 2.1-2.8.2.1;¶
(f) Subsection 2.1-2.8.10.2;¶
(g) Subparagraphs (2)(b)(vi) and (3)(b)(v) in subsection 2.1-5.1.2.2;¶
(h) Paragraph (b) in subsection A2.1-7.2.4;¶
(i) Paragraph (2) in subsection A2.1-8.3.3.1;¶
(j) Subsections 2.2-3.1.2 through 2.2-3.1.2.8;¶
(k) Subsection 2.2-3.1.8.17;¶
(l) Paragraph (4) in subsection A2.2-3.3.1.1;¶
(m) Paragraphs (1) and (2) in subsection 2.2-3.10.8.14;¶
(n) Chapter 2.3;¶
(o) Chapter 2.4; and¶
(p) Subsection 2.7-3.1.2.¶
(5) The following amendments or additions are made to the 2018, FGI, Guidelines for Design and Construction of Hospitals, as adopted and incorporated by reference. All references to part, subpart, sections, paragraphs, subparagraphs and appendices relate to the 2018, FGI, Guidelines for Design and Construction of Hospitals.¶
(a) Amend section 1.1-2 to read: "New Construction. Project submittal criteria shall comply with OAR chapter 333, division 675. Projects with any of the following scopes of work shall be considered new construction and shall comply with the requirements in the Guidelines for Design and Construction of Hospitals:" ¶
(b) Amend subsection 1.1-3.1.1.2 to read: "Major renovation projects. Project submittal criteria shall comply with OAR chapter 333, division 675. Projects with either of the following scopes of work shall be considered a major renovation and shall comply with the requirements for new construction in the Guidelines for Design and Construction of Hospitals to the extent possible as determined by the authority having jurisdiction: (1) A series of planned changes and updates to the physical plant of an existing facility. (2) A renovation project that includes modification of an entire building or an entire area in a building to accommodate a new use or occupancy."¶
(c) Amend subsection 1.1-3.1.2.1 to read: "Where major structural elements make total compliance impractical or impossible, exceptions shall be considered in accordance with the Oregon Administrative Rules specific to the physical environment of the type of hospital under consideration."¶
(d) Amend subsection 1.1-3.1.2.2 to read: "Minor renovation or replacement work shall be permitted to be exempted from the requirements in Section 1.1-3.1.1 (Compliance Requirements) provided they meet the criteria specified in OAR chapter 333, division 675 and do not reduce the level of health and safety in an existing facility."¶
(e) Amend subsection 1.1-3.1.4 to read: "Temporary Waivers. When parts of an existing facility essential to

continued overall facility operation cannot comply with particular standards during a renovation project, a temporary waiver of those standards shall be permitted as determined by the authority having jurisdiction if patient care and safety will not be jeopardized as a result. Reference Oregon Administrative Rules specific to the physical environment of the type of hospital under consideration."¶
(f) Amend section 1.1-8 to include the following codes and standards: ¶
(A) "ASHRAE 62.1: The Standards for Ventilation and Indoor Air Quality (2016)."¶
(B) "Building Industry Consulting Services International (BICSI) Standards (2018)."¶
(C) "NFPA 50: Standard for Bulk Oxygen Systems at Consumer Sites (2001)."¶
(D) "NFPA 99: Health Care Facilities Code (2012 as adopted by CMS)."¶
(E) "NFPA 101: Life Safety Code (2012 as adopted by CMS)."¶
(g) Amend paragraph (a) in subsection A1.2-2.1.1 to read: "(a) All projects, large and small, require a functional program to guide the design. The length and complexity of the functional program will vary greatly depending on project scope." ¶
(h) Amend subsection 1.2-2.1.2.1 to read: "The governing body shall be responsible for having a functional program developed, documented, and updated. The governing body may delegate documentation of the functional program to consultants with subject matter expertise. The governing body shall review and approve the functional program."¶
(i) Add subsection 1.2-2.2.7.4 to read: "A description of the following: (a) Special design feature(s); (b) Occupant load, numbers of staff, patients, visitors and vendors; (c) Issue of privacy/confidentiality for patient; (d) In treatment areas, describe: (A) Types of procedures; (B) Design considerations for equipment; (C) Requirements where the circulation patterns are a function of asepsis control; and (D) Highest level of sedation, if applicable."¶
(j) Amend subsection 1.2-4.1.1.2 to read: "To support this goal, an interdisciplinary team shall develop a safety risk assessment (SRA). A copy of the SRA shall accompany instruction documents submitted to the Oregon Health Authority, Facility Planning and Safety program."¶
(k) Add paragraphs (1) through (4) and amend subsection 1.2-4.6.1 to read: "Behavioral and Mental Health Elements of the Safety Risk Assessment. The SRA report shall identify areas where patients at risk of mental health injury and suicide will be served. Elements of the assessment shall include but not be limited to: (1) A statement explaining the psychiatric population groups served; (2) A discussion of the capability for staff visual supervision of patient ancillary areas and corridors; (3) A discussion of the risks to patients, including self-injury, and the project solutions employed to minimize such risks; and (4) A discussion of building features and equipment, including items which may be used as weapons, that is intended to minimize risks to patients, staff and visitors."¶
(l) Amend paragraph (d) in subsection A1.2-5.4.5 to read: "(d) In facilities with multi-bed rooms, family consultation rooms or grieving rooms, in addition to family lounges, should be provided to permit patients and families to communicate privately."¶
(m) Amend 1.2-6.1.1 to read: "General. The planning and design of new hospitals and the retrofitting of existing hospitals shall conform to the Guidelines and all applicable codes and regulations with respect to exterior environmental sound and interior sound within all occupied building spaces. Documentation by a Licensed Acoustic Engineer of compliance with acoustic criteria, shall be accepted as equivalency to the requirements of Table 1.2-4 Noise Reduction Coefficient (NRC) and Table 1.2-6 Sound Transmission Class (STC.)"¶
(n) Amend paragraph (1) in subsection 2.1-2.3.1.1 to read: "(1) All patient care areas designated for care of patients of size shall meet the requirements in this section. The Oregon Health Authority ~~(Authority)~~ will complete a review when specifically cross-referenced from a FGI facility type requirement section or when identified in the project submission documents." ¶
(o) Amend subsection 2.1-2.4.1 to read: "The special patient care room requirements in this section shall apply to all facilities that provide these rooms. See facility chapters for other specific requirements. Requirements for other types of special patient care rooms are located in the facility chapters. Where monolithic ceilings are provided in airborne infection isolation (AII) rooms or seclusion rooms, the NRC standards listed in Table 1.2-4 are not required." ¶
(p) Amend paragraph (2)(a) in subsection 2.1-2.8.2.1 to read: "(a) At least one hand-washing station shall be provided within 20 feet and not through a door. See section 2.1-7.2.2.8 (Hand-washing stations) for requirement."¶
(q) Amend paragraph (1) in subsection 2.1-2.8.7.3 to read: "(1) At least one hand-washing station shall be provided for every four patient care stations or fewer."¶
(r) Amend subparagraph (2)(d) in subsection 2.1-2.8.8.1 to read: "(d) Lighting. Task-specific lighting levels, measured at the worksurface only, for health care settings recommended in the U.S. Pharmacopeia-National Formulary shall be used to design lighting."¶
(s) In subsection 2.1-2.8.8.2:¶
(A) Amend the title to read: "Work areas for preparing and dispensing medication. Facilities shall be reviewed

below for each area as applicable as either subparagraph (1) or as subparagraph (2) if only dispensing."¶
(B) Amend paragraph (1) to read: "(1) Medication preparation room or area"¶
(C) Amend subparagraph (1)(a) to read: "(a) This room or area shall be under direct or indirect (example, camera) visual control of the nursing staff."¶
(D) Amend subparagraph (1)(b) to read: "(b) This room or area shall contain the following:" ¶
(E) Amend subparagraph (1)(b)(ii) to read: "(ii) Hand-washing station unless located within an operating room, c-section room, Class 3 imaging, or sterile core of surgical department. Where hand-washing station is omitted in the sterile core, a hand sanitation dispenser shall be provided."¶
(F) Amend subparagraph (1)(b)(iii) to read: "(iii) Lockable refrigerator where refrigerated medications are used."¶
(G) Amend subparagraph (1)(c) to read: "(c) Where a medication preparation room or area is used to store one or more self-contained medication-dispensing units, the room shall be designed with space to prepare medication when the self-contained medication dispensing unit(s) are present."¶
(H) Amend subparagraph (2)(c) to read: "(c) A hand-washing station shall be located next to stationary medication-dispensing units or stations unless the medication-dispensing unit, station, or cart is located within an operating room, c-section room, Class 3 imaging, or sterile core of surgical department. Where hand-washing station is omitted in the sterile core, a hand sanitation dispenser shall be provided." ¶
(t) Amend subsection 2.1-2.8.10.1 to read: "Ice-making equipment shall be of the self-dispensing type."¶
(u) Amend paragraph (1) in subsection 2.1-2.8.12.3 to read: "(1) Hand-washing station."¶
(v) Amend subsection 2.1-2.8.14.2 to read: "Environmental services room shall be a minimum of 35 square feet. Each environmental services room shall be provided with the following: (1) Service sink or floor-mounted mop sink; (2) Provisions for storage of supplies and housekeeping equipment; (3) Hand-washing station or hand sanitation dispenser."¶
(w) Amend subparagraph (1)(a) in subsection 2.1-4.1.2.6 to read: "(a) Terminal sterilization is not required for waste that is incinerated on-site or when services for regulated medical/bio-hazard waste disposal services will be contracted through a vendor." ¶
(x) Add paragraph (3) to subsection 2.1-4.2.3.1 to read: "(3) Pharmacy clean/sterile compounding rooms accessed from an ante room need not comply with Table 1.2-4: Minimum Design Room-Average Sound Absorption Coefficients."¶
(y) Amend subsection 2.1-4.2.8.7 to read: "A hand-washing station(s) shall be provided within each separate room where open medication is prepared for administration except where prohibited by OAR chapter 855, division 045; USP 797 or USP 800. Where a hand-wash station is prohibited in the compounding room, a hand-wash station(s) shall be provided in an anteroom."¶
(z) Add paragraph (5) to subsection 2.1-4.3.1.3 to read: "(5) All offered dietary services shall comply with Oregon Health Authority Food Sanitation Rules, chapter 333, division 150 and other authorities having jurisdiction."¶
(aa) Add subparagraphs (2)(a) through (c) in subsection 2.1-5.2.2.2 to read: "(a) Washers/extractors. Washers/extractors shall be located between the soiled linen receiving and clean process areas. Washers/extractors shall provide a temperature of at least 160 degrees Fahrenheit for a minimum of 25 minutes or include use of a chemical disinfectant; (b) Dryers; (c) Supply storage. Storage shall be provided for laundry supplies."¶
(bb) In subsection 2.1-5.4.1.3:¶
(A) Add subparagraphs (1)(a)(i) and (ii) to read: "(i) Wall base shall be integral and coved with the floor, tightly sealed to the wall, and constructed without voids that can harbor insects. (ii) Shall have hand sanitation dispenser in or adjacent to interior regulated waste storage spaces."¶
(B) Amend subparagraph (2)(a) to read: "(a) Illumination per Illuminating Engineering Society of North America (IES) standards."¶
(C) Add paragraph (4) to read: "(4) Regulated waste management shall be in accordance with the requirements of OAR chapter 333, division 056."¶
(cc) Amend subsection 2.1-6.2.7.1 to read: "Storage. A designated area located out of the required corridor width and directly accessible to the entrance shall be provided for storage of at least one wheelchair."¶
(dd) Amend subparagraph (3)(b) in subsection 2.1-7.2.2.8 to read: "(b) For newly constructed or newly installed countertops that require a substrate, marine-grade plywood (or equivalent material) with an impervious seal shall be required. Existing countertops shall be fully sealed/caulked and in good repair."¶
(ee) Add paragraph (4) to subsection 2.1-7.2.2.11 to read: "(4) All imaging facilities and radiation producing equipment installations must comply with OAR chapter 333, divisions 100 through 123, and be licensed by the Oregon Health Authority, Radiation Protection Services program."¶
(ff) Add subsection 2.1-7.2.2.15 to read: "Work Surfaces: Work Areas. Where a work space, work area, work counter, or work surface is provided, it shall have a minimum of 4 square feet (.37 square meter) of contiguous clear surface for each person programmed to work in the space at the same time. A mobile cart meeting these requirements shall be permitted."¶

(gg) Add subparagraphs (xi) through (xvi) to subparagraph (7)(a) in subsection 2.1-7.2.3.1 to read: "(xi) Bathing and toilet rooms. (xii) Soiled workrooms and soiled hold rooms. (xiii) Environmental services rooms. (xiv) Pharmacy clean and anterooms. (xv) Emergency department trauma rooms. (xvi) Emergency department exam/treatment rooms."¶
(hh) Amend paragraph (2) in subsection 2.1-8.3.3.1 to read: "Stored fuel is required and storage capacity shall permit continuous operation for at least 96 hours. An Extended Stay Center shall provide fuel for emergency power to meet longest expected patient stay."¶
(ii) Amend subsection 2.1-8.3.5.2 to read: "Electronic health record system servers and centralized storage. This equipment shall be provided with an uninterruptible power supply and connected to the essential electrical system."¶
(jj) Amend paragraph (2) in subsection 2.1-8.4.2.5 to read: "(2) Heated potable water distribution system serving patient care areas shall be under constant recirculation to provide continuous hot water at each hot water outlet and shall meet the standards specified in Table A2.1-a."¶
(kk) In subsection 2.1-8.4.2.6:¶
(A) Amend subparagraph (1)(a) to read: "(a) Where sanitary or storm drainage piping is installed above the ceiling of, or exposed in, operating and delivery rooms, procedure rooms, trauma rooms, nurseries, central kitchens, sterile processing facilities, Class 2 and 3 imaging rooms, electronic mainframe rooms (TSERs and TECs), main switchgear and electrical rooms, electronic data processing areas, or electric closets, the piping shall have special provisions (e.g., double wall containment piping or oversized drip pans) to protect the space below from leakage and condensation."¶
(B) Add subparagraph (1)(c) to read: "(c) FM 1680 compliant no-hub couplings shall be acceptable in lieu of standards specified in paragraphs (a) and (b)."¶
(ll) Amend subparagraph (5)(a)(i) in subsection 2.2-2.2.4.4 to read: "(i) The ceiling shall be monolithic. The NRC standards listed in Table 1.2-4 are not required."¶
(mm) Add subparagraph (2)(c)(v) in subsection 2.2-2.2.4.6 to read: "(v) Hidden alcoves are prohibited."¶
(nn) In subsection 2.2-3.1.3.3:¶
(A) Amend paragraph (~~3~~1) ~~in subsection 2.2-3.1.3.3~~to read (1)(a).¶
(B) Add paragraph (1)(b) and subparagraphs (i) and (ii) to read: (1)(b) Effective [insert effective date of rules,] bullet-resistant construction including glazing, doors, and walls shall be provided at all emergency department intake areas where patients are registered. (i) The intake area shall provide UL 752 level 3 protection. (ii) Ballistic protection shall extend from the floor to a height of 7 feet, 0 inches at exposed glazing, doors and walls of the intake area. (iii) Ballistic protection shall extend at exposed walls adjacent to the intake area, from the floor to a height of 7 feet, 0 inches. Protection shall be provided at the exposed intake area sidewalls. (iv) Level of ballistic protection at walls shall meet or exceed required glazing protection."¶
(C) Amend paragraph (3) to read: "(3) The triage area, room or bay shall be a minimum of 80 square feet and shall include the following:"¶
(oo) Add paragraph (4) to subsection 2.2-3.1.4.2 to read: "Where monolithic ceilings are provided in airborne infection isolation (AII) rooms, secure holding rooms, or flex behavioral health rooms (flex between secure hold and regular treatment) and are located in the emergency department, the NRC standards listed in Table 1.2-4 are not required." ¶
(pp) Amend subsection 2.2-3.1.4.3 to read: "Secure holding room. If psychiatric services are provided, a secure holding room shall be provided and it shall meet the following requirements. (1) The location of the secure holding room(s) shall facilitate staff observation and monitoring of patients in these areas. (2) The secure holding room shall have a minimum clear floor area of 60 square feet (5.57 square meters) with a minimum wall length of 7 feet (2.13 meters) and a maximum wall length of 11 feet (3.35 meters). (3) This room shall be designed to prevent injury to patients. (a) All finishes, light fixtures, vents and diffusers, and sprinklers shall be impact-, tamper-, and ligature-resistant. (b) There shall not be any electrical outlets, medical gas outlets, or similar devices. (c) There shall be no sharp corners, edges, or protrusions, and the walls shall be free of objects or accessories of any kind. (d) Patient room doors shall swing out and shall have hardware on the exterior side only. (e) A small impact-resistant view panel or window shall be provided in the door for discreet staff observation of the patient. (4) Door openings shall be provided in accordance with Section 2.1-7.2.2.3 (2)(a)(i) (Door openings-Minimum for patient rooms and diagnostic and treatment areas&)."¶
(qq) Amend paragraph (4) in subsection 2.2-3.1.8.2 to read: "(4) Visual observation of all traffic into and within the unit shall be provided from the nurse station through direct or indirect visual observation."¶
(rr) Amend subsection 2.2-3.1.8.12 to read: "A soiled workroom(s) shall be provided for the exclusive use of the emergency department in accordance with Section 2.1-2.8.12 (Soiled Workroom or Soiled Holding Room)."¶
(ss) Amend paragraph (4) in subsection 2.2-3.2.8.2 to read: "(4) Soiled workroom. A soiled workroom shall be provided in accordance with Section 2.1-2.8.12 (Soiled Workroom or Soiled Holding Room)."¶
(tt) Add subparagraphs (4)(a) through (c) to subsection 2.2-3.3.1.1 to read: "(a) Unrestricted area: Any area of the

surgery department that is not defined as semi-restricted or restricted. These areas shall include a central control point for designated personnel to monitor the entrance of patients, personnel, and materials into the semi-restricted areas; staff changing areas; a staff lounge; offices; waiting rooms or areas; pre- and postoperative patient care areas; and access to procedure rooms (e.g., endoscopy procedure rooms, laser treatment rooms). Street clothes are permitted in these areas. Public access to unrestricted areas may be limited based on the facility's policy and procedures. (b) Semi-restricted area: Peripheral areas that support surgical services. These areas shall include storage for equipment and clean and sterile supplies; work areas for processing instruments; sterile processing facilities; hand scrub stations; corridors leading from the unrestricted area to the restricted area of the surgical suite; and entrances to staff changing areas, pre- and postoperative patient care areas, and sterile processing facilities. The semi-restricted area of the surgical suite is entered directly from the unrestricted area past a nurse station or from other areas. Semi-restricted areas have specific HVAC design requirements associated with the intended use of the space (see Part 3: ANSI/ASHRAE/ASHE 170: Ventilation of Health Care Facilities). Personnel in the semi-restricted area shall wear surgical attire and cover all head and facial hair. Access to the semi-restricted area shall be limited to authorized personnel and patients accompanied by authorized personnel. (c) Restricted area: A designated space contained within the semi-restricted area and accessible only through a semi-restricted area. The restricted area includes operating and other rooms in which operative or other invasive procedures are performed. Restricted areas have specific HVAC design requirements associated with the intended use of the space (see Part 3: ASHRAE/ASHE 170). Personnel in the restricted area shall wear surgical attire and cover head and facial hair. Masks shall be worn when the wearer is in the presence of open sterile supplies or of persons who are completing or have completed a surgical hand scrub. Only authorized personnel and patients accompanied by authorized personnel shall be admitted to this area."¶
(uu) Add paragraph (3) in subsection 2.2-3.3.2.1 to read: "(3) Procedure rooms where monolithic ceilings are required or provided, the NRC standards listed in Table 1.2-4 are not required." ¶
(vv) In subsection 2.2-3.3.10.3:¶
(A) Amend paragraph (1) to read: "(1) A changing area that includes the following shall be provided for patients. (a) Toilet(s); (b) Space for changing or gowning."¶
(B) Add paragraph (3) to read: "(3) Individual, lockable storage shall be provided for patients' belongings."¶
(ww) In subsection 2.2-3.4.1.2, add the following paragraphs to read: "(1) Class 2 imaging shall include electrophysiology procedures and cardiac catheterization labs unless the facility chooses to identify and design them as Class 3 imaging. (2) Imaging Services for which an anesthesia machine is used only to immobilize the patient (for the benefit of the imaging exam) shall be permitted in Class 1 imaging rooms in which the following criteria are met: (a) Anesthesia is provided exclusively for the benefit of the patient (for example, to assuage anxiety or claustrophobia) or to combat patient motion that may interfere with exam results. (b) The imaging room shall provide a clearance of 4 feet around all sides of a freestanding imaging device, including a patient table/bed/couch, gantry, or assembly. Omission of this clearance shall be permitted on the side(s) of an imaging device that is mounted to/placed against a wall. (c) The imaging room meets the Class 2 electrical receptacle requirements of Table 2.1-1 (Electrical Receptacles for Patient Care Areas in Hospitals). (d) The imaging room meet the Class 2 nurse call requirements of Table 2.1-2 (Locations for Nurse Call Devices in Hospitals). (e) The imaging room meets the Class 2 medical gas and vacuum system requirements of Table 2.1-3 (Oxygen, Vacuum, Medical Air, WAGD, and Instrument Air Systems). (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." ¶
(xx) In subsection 2.2-3.4.1.3: ¶
(A) Add subparagraph (1)(c)(i) to read: "(i) A minimum of 1 foot 6 inches between the view window and the outside partition edge shall be provided."¶
(B) Add subparagraph (1)(d) to read: "(d) The control room shall be physically separated from the Class 2 or Class 3 imaging room with walls and a door. The door shall not be required where the control room serves only one imaging room that is built, maintained, and controlled the same as the imaging room and does not contain system components identified in 2.2-3.4.2.5."¶
(yy) Amend subparagraph (1)(a) in subsection 2.2-3.4.2.5 to read: "(a) For Class 2 and Class 3 imaging rooms considered new construction or major renovation, the system component room shall not open into the imaging room or any restricted space." ¶
(zz) In subsection 2.2-3.4.10.2: ¶
(A) Amend paragraph (1) to read: "(1) Patient toilet rooms shall be immediately accessible to sub-waiting rooms or areas and patient changing rooms where provided."¶
(B) Amend subparagraph (3)(a) to read: "(a) Patient toilet rooms reserved for nuclear imaging patients shall be provided immediately accessible to sub-waiting rooms or areas and nuclear imaging rooms." ¶
(aaa) Amend paragraph (2) in subsection 2.2-3.5.8.15 to read: "(2) Each examination room shall be equipped with a

hand-washing station and a work counter."¶
(bbb) Amend subsection 2.2-3.10.2.4 to read: "Patient privacy. Space shall be available to accommodate provisions for patient privacy including when patients are examined or treated and body exposure is required. Privacy must be provided for the use of a bedpan or commode during dialysis, initiating and discontinuing treatment when the vascular access is placed in an intimate area, for physical exams, and for sensitive communications. There shall be sufficient numbers of privacy screens or other methods of visual separation available and used to afford patients full visual privacy when indicated."¶
(ccc) Add subparagraphs (1)(a) and (b) to subsection 2.2-3.10.2.5 to read: "(a) Wrist blade controls are not considered to be operable without the use of the hands. (b) Exception: Home training room hand-wash stations may be trimmed with residential style, ADA compatible controls."¶
(ddd) Add subsection 2.2-3.10.2.6 to read: "Body Fluid Disposal Sink. A fluid disposal sink shall be provided in each hemodialysis treatment area or room. Sink design including signage and location shall be constructed to prevent cross-contamination of the hand washing station."¶
(eee) Add subsection 2.2-3.10.2.7 to read: "Emergency Equipment. Emergency cart and equipment storage located close to the patient treatment area, readily accessible by staff, and not located in an exit path."¶
(fff) In subsection 2.2-3.10.3.2:¶
(A) Amend paragraph (3) to read: "(3) Separate sink with identifying signage that it is for fluid disposal."¶
(B) Add paragraph (4) to read: "(4) Emergency nurse call."¶
(ggg) Amend reference to subsections 2.2-3.10.4 - 2.2.3.10.7 to read:¶
(A) "2.2-3.10.4 Special Patient Care Rooms."¶
(B) "2.2-3.10.4.1 Isolation Room."¶
(C) "2.2-3.10.4.1.1 An isolation room shall be provided for Hepatitis B positive (HBV+) patients to prevent contact transmission of HBV+ blood spills and other body fluids. The isolation room shall meet the following requirements: (1) Provides a door and walls that go to the floor, but not necessarily the ceiling, and allows for visual monitoring of the patient; (2) Accommodates only one patient; (3) A hand washing station; and (4) A separate sink shall be provided within the isolation room for fluid disposal. Sink design including signage and location shall be constructed to prevent cross-contamination of the hand washing station."¶
(D) "2.2-3.10.4.1.2 The isolation room shall have a minimum clear floor area of 120 square feet."¶
(E) "2.2-3.10.4.1.3 The isolation room shall allow for direct observation of the patient by staff from a patient care staff station. Direct observation must include patient face and insertion point."¶
(F) "2.2-3.10.5 - 2.2-3.10.7 Reserved".¶
(hhh) Amend paragraph (2) in subsection 2.2-3.10.8.2 to read: "(2) The nurse station(s) shall be no higher than 3 feet 8 inches and be designed to provide direct visual observation of all individual dialysis treatment bays. Direct observation must include patient face and insertion point."¶
(iii) Amend subsection 2.2-3.10.8.12 to read: "Soiled holding room. A soiled holding room shall be provided in accordance with Section 2.1-2.8.12 (Soiled Workroom or Soiled Holding Room)."¶
(jjj) Amend subsection 2.2-3.10.8.14 to read: "An environmental services room shall be provided that meets the requirements in Section 2.1-2.8.14 (Environmental Services Room)."¶
(kkk) Amend subsection 2.2-3.10.8.19 to read: "An equipment repair and breakdown room shall be provided, and be equipped with the following: (1) Hand-washing station; (2) Treated water outlet for equipment maintenance and drain or clinical service sink for equipment connection and testing; (3) Work counter; (4) Storage cabinet."¶
(lll) Add paragraph (3) under subsection 2.2-3.11.2.1 to read: "(3) Where monolithic ceilings are provided in endoscopy procedure rooms, the NRC standards listed in Table 1.2-4 are not required." ¶
(mmm) Amend subparagraph (1)(a) in subsection 2.2-3.11.10.3 to read: "(a) Patient changing areas. Provisions for storing patients' belongings. Individual, lockable storage shall be provided."¶
(nnn) Amend subparagraph (1)(c) in subsection 2.2-3.13.10.3 to read: "(c) Provisions for hanging patients' clothing and individual, lockable storage for securing valuables."¶
(ooo) Amend paragraph (1) in subsection 2.5-2.2.2.6 to read: "(1) Each patient shall have access to a toilet room without having to enter a corridor."¶
(ppp) Amend subsection 2.5-2.3.2.1 to read: "Capacity. (1) The maximum number of beds per room shall be one unless the necessity of a two-bed arrangement has been demonstrated. Two beds per room shall be permitted where approved by the authority having jurisdiction. (2) Where renovation work is undertaken and the present capacity is more than one bed, the maximum room capacity shall be two beds."¶
(qqq) Amend subsection 2.5-2.3.2.3 to read: "Patient toilet room. (1) Each patient shall have direct access to a toilet room. (2) One toilet room shall serve no more than two patient bedrooms and no more than four patients. (3) The toilet room shall contain a toilet and a hand-washing station. (4) Toilet room doors: (a) Where indicated by the safety risk assessment, toilet room doors shall be equipped with keyed locks that allow staff to control access to the toilet room. (b) Where a swinging door is used, the door to the toilet room shall swing outward or be double-acting."¶

(rrr) Amend subsection 2.5-2.3.4 to read: "Outdoor Areas. An outdoor activity area shall be provided with a minimum of 50 square feet per patient but not less than 400 total square feet, see Section 2.5-2.2.3 (General Psychiatric Patient Care Unit-Outdoor Areas) for requirements."¶
(sss) Amend paragraph (1) in subsection 2.6-2.2.8.1 to read: "(1) The support areas noted shall be provided in or readily accessible to each patient care unit and meet the requirements in Section 2.2-2.2.8 (Support Areas for Medical/Surgical Patient Care Units) as amended in this section."¶
(ttt) Amend subsection 2.7-3.1.3.1 to read: "Children's hospitals shall have facilities for the services they provide that meet the requirements in Section 2.2-3.1.3 (Emergency Department) as amended by the children's hospitals-specific emergency department requirements in this section."¶
(uuu) Amend subsection 2.7-3.1.3.6 to read: "Treatment room. Treatment rooms shall meet the requirements in Section 2.2-3.1.3.6(5) (Pediatric treatment rooms)."¶
(vvv) Add subsection 2.8-1.1.1.4 to read: "This chapter shall not be reviewed for Class 1 imaging mobile/transportable medical units that are to be used for less than 180 calendar days in a consecutive 12-month period while the permanent equipment and imaging space is receiving renovation or replacement work. Interim life safety measures shall be implemented and made available for review and inspection upon request. Documents shall record the arrival date and removal date of the trailer. A copy of these record documents shall be with the trailer for duration of placement." ¶
(www) Amend subsection 2.8-1.3.7.4 to read: "Applicable local and state requirements. All imaging facilities and radiation producing equipment installations must comply with OAR chapter 333, divisions 100 through 123, and be licensed by the Oregon Health Authority, Radiation Protection Services program."¶
(xxx) Amend subsection 2.8-3.1.2 to read: "All mobile/transportable medical units shall be provided with a hand-washing station in accordance with Section 2.1-2.8.7 (Hand-Washing Station). For Class 1 imaging units that are not already provided with a hand-washing station, a hand-sanitation dispenser shall be provided instead."¶
(6) The following chapters, sections, paragraphs, subparagraphs or appendices of the 2018, FGI, Guidelines for Design and Construction of Outpatient Facilities are deleted in their entirety:¶
(a) Subsection A1.2-2.1.2.1;¶
(b) Subsection 1.2-2.1.2.3;¶
(c) Section 1.2-8;¶
(d) Section 1.2-9;¶
(e) Paragraph (b) in subsection A2.1-3.6;¶
(f) Subsection 2.1-3.8.10.2;¶
(g) Subparagraphs (2)(b)(vi) and (3)(b)(v) in subsections 2.1-4.3.2.2;¶
(h) Paragraph (7) in subsection A2.1-7.2.2.8;¶
(i) Subsection 2.4-6.2.2 through A2.4-6.2.3;¶
(j) Subsection A2.7-3.1.1.4;¶
(k) Subsection A2.10-3.4.1; and¶
(l) Chapter 2.8; ¶
(m) Subsection 2.11-3.2.7.1 through 2.11-3.2.7.5; ¶
(n) Subsection 2.11-3.2.9.1 through 2.11-3.2.9.10; and¶
(o) Subsection 2.11-3.2.10.¶
(7) The following amendments or additions are made to the 2018, FGI, Guidelines for Design and Construction of Outpatient Facilities, as adopted and incorporated by reference. All references to part, subpart, sections, paragraphs, subparagraphs and appendices relate to the 2018, FGI, Guidelines for Design and Construction of Outpatient Facilities.¶
(a) Amend section 1.1-2 to read: "Project submittal criteria shall comply with OAR chapter 333, division 675. Projects with any of the following scopes of work shall be considered new construction and shall comply with the requirements in the Guidelines for Design and Construction of Outpatient Facilities:"¶
(b) Amend subsection 1.1-3.1.1.2 to read: "Major renovation projects. Project submittal criteria shall comply with OAR chapter 333, division 675. Projects with either of the following scopes of work shall be considered a major renovation and shall comply with the requirements for new construction in the Guidelines for Design and Construction of Outpatient Facilities to the extent possible as determined by the authority having jurisdiction: (1) A series of planned changes and updates to the physical plant of an existing facility, (2) A renovation project that includes modification of an entire building or an entire area in a building to accommodate a new use or occupancy."¶
(c) Amend subsection 1.1-3.1.2.1 to read: "Where major structural elements make total compliance impractical or impossible, exceptions shall be considered in accordance with the Oregon Administrative Rules specific to the physical environment of the type of health care facility under consideration."¶
(d) Amend subsection 1.1-3.1.2.2 to read: "Minor renovation or replacement work shall be permitted to be exempted from the requirements in Section 1.1-3.1.1 (Compliance Requirements) provided they meet the criteria

specified in OAR chapter 333, division 675 and do not reduce the level of health and safety in an existing facility."¶
(e) Amend paragraph (a) in subsection A1.2-2.1.1 to read: "(a) All projects, large and small, require a functional program to guide the design. The length and complexity of the functional program will vary greatly depending on project scope."¶
(f) Amend subsection 1.2-2.1.2.1 to read: "The governing body shall be responsible for having a functional program developed, documented, and updated. The governing body may delegate documentation of the functional program to consultants with subject matter expertise. The governing body shall review and approve the functional program."¶
(g) Add new subsection 1.2-2.2.7.4 to read: "A description of the following: (a) Special design feature(s); (b) Occupant load, numbers of staff, patients, visitors and vendors; (c) Issue of privacy/confidentiality for patient; (d) In treatment areas, describe: (A) Types of procedures; (B) Design considerations for equipment; (C) Requirements where the circulation patterns are a function of asepsis control; and (D) Highest level of sedation, if applicable; (e) For Outpatient Surgery facilities, the functional program must also describe: (A) Level of medical gas system per NFPA 99; and (B) Type of central electrical system."¶
(h) Amend subsection 1.2-4.1.1.2 to read: "To support this goal, an interdisciplinary team shall develop a safety risk assessment (SRA). A copy of the SRA shall accompany construction documents submitted to the Oregon Health Authority, Facility Planning and Safety program."¶
(i) Add paragraphs (1) through (4) and amend subsection 1.2-4.6.1 to read: "Behavioral and Mental Health Elements of the Safety Risk Assessment. The SRA report shall identify areas where patients at risk of mental health injury and suicide will be served. Elements of the assessment shall include but are not limited to: (1) A statement explaining the psychiatric population groups served; (2) A discussion of the capability for staff visual supervision of patient ancillary areas and corridors; (3) A discussion of the risks to patients, including self-injury, and the project solutions employed to minimize such risks; and (4) A discussion of building features and equipment, including items which may be used as weapons, that is intended to minimize risks to patients, staff and visitors."¶
(j) Amend subsection 1.2-6.1.1 to read: "General. The planning and design of new outpatient facilities and the retrofitting of existing outpatient facilities shall conform to the Guidelines and all applicable codes and regulations with respect to exterior environmental sound and interior sound within all occupied building spaces. Documentation by a Licensed Acoustic Engineer of compliance with acoustic criteria, shall be accepted as equivalency to the requirements of Table 1.2-4 NRC and Table 1.2-6 STC."¶
(k) Amend subsection 2.1-2.1.1.1 to read: "All patient care areas designated for care of patients of size shall meet the requirements in this section. The Oregon Health Authority will complete a review when specifically cross-referenced from a FGI facility type requirement section or when identified in the project submission documents." ¶
(l) Add subparagraph (3)(f) to subsection 2.1-3.2.1.2 to read: "(f) Work counter that complies with 2.1-7.2.2.15 (Work Surfaces)."¶
(m) Add paragraph (3) to subsection 2.1-3.2.2.1 to read: "(3) Procedure rooms where monolithic ceilings are required or provided, the NRC standards listed in Table 1.2-4 are not required." ¶
(n) Add paragraph (4) to subsection 2.1-3.2.2.7 to read: "(4) Provision for in-room storage of supplies and equipment used in procedure room. May be fixed cabinets or movable cart(s)."¶
(o) Amend paragraph (12) in subsection 2.1-3.2.2.8 to read: "(12) Soiled holding. A dedicated soiled hold room or space for holding soiled materials shall be provided that is separate from the clean storage area."¶
(p) Amend paragraph (4) in subsection 2.1-3.2.2.10 to read: "(4) Storage for patients' belongings. Provisions shall be made for securing patients' personal effects during procedures. Individual, lockable storage shall be provided."¶
(q) Amend subsection 2.1-3.2.3.8:¶
(A) Subparagraph (1)(b) to read: "(b) Sharing of these support areas with other clinical services in the facility shall be permitted. An ambulatory surgical center (ASC) that is Medicare-certified must be distinct from any other health care facility or office-based physician practice as required in 42 CFR 416.2 and 42 CFR 416.44(a)(2) and (b)"; and¶
(B) Paragraph (12) to read: "(12) Soiled workroom meeting requirements in 2.1-3.8.12. A room for holding soiled material shall be provided that is separate from the clean storage area."¶
(r) Amend paragraph (4) in subsection 2.1-3.2.3.10 to read: "(4) Storage for patients' belongings. Provisions shall be made for securing patients' personal effects during surgery. Individual, lockable storage shall be provided."¶
(s) Amend subsection 2.1-3.5.1.2 to read: "To differentiate the design and construction requirements needed to achieve the environmental controls and other requirements that support the amount of intervention to be provided, imaging rooms shall be classified as described in Table 2.1-5 (Classification of Room Types for Imaging Services). (1) Class 2 imaging shall include electrophysiology procedures and cardiac catheterization labs unless

the facility chooses to identify and design them as Class 3 imaging. (2) Imaging Services for which an anesthesia machine is used only to immobilize the patient (for the benefit of the imaging exam) shall be permitted in Class 1 imaging rooms in which the following criteria are met: (a) Anesthesia is provided exclusively for the benefit of the patient (for example, to assuage anxiety or claustrophobia) or to combat patient motion that may interfere with exam results. (b) The imaging room shall provide a clearance of 4 feet around all sides of a freestanding imaging device, including a patient table/bed/couch, gantry, or assembly. Omission of this clearance shall be permitted on the side(s) of an imaging device that is mounted to/placed against a wall. (c) The imaging room meets the Class 2 electrical receptacle requirements of Table 2.1-1 (Electrical Receptacles for Patient Care Areas in Outpatient Facilities). (d) The imaging room meet the Class 2 nurse call requirements of Table 2.1-3 (Locations for Nurse Call Devices in Outpatient Facilities). (e) The imaging room meets the Class 2 medical gas and vacuum system requirements of Table 2.1-2 (Station Outlets for Oxygen, Vacuum, Medical Air, WAGD, and Instrument Air Systems in Outpatient Facilities). (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."¶

(t) In subsection 2.1-3.5.1.3:¶

(A) Amend subparagraph (1)(c) to read: "(c) Shielded view window. The control alcove or room shall include a shielded view window designed to provide a full view of the examination/procedure table and the patient at all times, including a full view of the patient during imaging activities (e.g., when the table is tilted or the chest X-ray is in use). Where protected alcoves with view windows are required, a minimum of 1 foot 6 inches between the view window and the outside partition edge shall be provided."¶

(B) Amend subparagraph (1)(d) to read: "(d) The control room shall be physically separated from the Class 2 or Class 3 imaging room with walls and a door. The door shall not be required where the control room serves only one imaging room that is built, maintained, and controlled the same as the imaging room and does not contain system components identified in 2.1-3.5.2.5."¶

(u) Amend paragraph (3) in subsection 2.1-3.5.2.1 to read: "(3) Where imaging procedures meeting Class 3 criteria are performed, a room(s) that meets the requirements for the applicable imaging suite and for an operating room (see Section 2.1-3.2.3) shall be provided. These imaging rooms shall comply with the following: (a) Be sized to accommodate the personnel and equipment planned to be in the room during procedures. (b) Have a minimum clear floor area of 600 square feet (55.74 square meters) with a minimum clear dimension of 20 feet (6.10 meters). (c) Where renovation work is undertaken and it is not possible to meet the above minimum standards, these rooms shall have a minimum clear floor area of 500 square feet (46.50 square meters) with a minimum clear dimension of 20 feet (6.10 meters). (d) Fixed encroachments into the minimum clear floor area. Fixed encroachments shall be permitted to be included when determining the minimum clear floor area for an operating room as long as: (i) There are no encroachments into the sterile field. (ii) The encroachments do not extend more than 12 inches (30.5 centimeters) into the minimum clear floor area outside the sterile field. (iii) The encroachment width along each wall does not exceed 10 percent of the length of that wall."¶

(v) Amend paragraph (1)(a) in subsection 2.1-3.5.2.5 to read: "(a) For Class 2 and Class 3 imaging rooms considered new construction or major renovation, the system component room shall not open into the imaging room or any restricted space."¶

(w) Add paragraph (5) to subsection 2.1-3.5.4.4 to read: "(5) Where patients change in the mammography room, privacy shall be provided."¶

(x) In subsection 2.1-3.5.10.2: ¶

(A) Amend paragraph (1) to read: "(1) Patient toilet rooms shall be immediately accessible to sub-waiting rooms or areas and patient changing rooms where provided."¶

(B) Amend subparagraph (3)(a) to read: "(a) Patient toilet rooms reserved for nuclear imaging patients shall be provided immediately accessible to sub-waiting rooms or areas and nuclear imaging rooms."¶

(y) Add new subsection 2.1-3.6.2.4 to read: "Hybrid imaging/therapy systems. Where external beam radiation therapy systems are combined with a concurrent imaging option (for example, CT or MRI), the full design criteria for both contributing imaging/therapy devices shall be applied to the hybrid service."¶

(z) Amend subsection A2.1-3.6.8.16 to read: "Other support areas for radiation therapy. In addition to the optional support areas in the main text, the following support areas may be needed to support radiation therapy services: (a) Dosimetry equipment area or storage for calibration phantoms. (b) Workstation/nutrition station."¶

(aa) Add new subsection 2.1-3.6.8.17 to read: "Additional Support Areas. (1) Control room or area: (a) All external beam radiation therapy treatment and simulator rooms shall have a control room or area. (b) Control room shall have visual and audio contact with patient in the treatment room. Visual contact may be direct or by video link. (2) Treatment planning and record room, if provided, shall be sized to meet manufacturers' dosimetry system requirements. (3) Consultation room shall be provided for radiation therapy suite."¶

(bb) Amend subsection 2.1-3.8.2.5 to read: "Hand-wash station shall be provided within 20 feet, not through a

door. See section 2.1-7.2.2.8 (Hand-washing stations) for requirements."¶
(cc) Amend paragraph (1) in subsection 2.1-3.8.7.3 to read: "(1) At least one hand-washing station shall be provided for every four patient care stations or fewer."¶
(dd) Amend subparagraph (2)(d) in subsection 2.1-3.8.8.1 to read: "(d) Lighting. Task-specific lighting levels, measured at the worksurface only, for health care settings recommended in the U.S. Pharmacopeia-National Formulary shall be used to design lighting."¶
(ee) Amend subsection 2.1-3.8.8.2 to read: "Work areas for preparing and dispensing medication. Facilities shall be reviewed below for each area as applicable as either subparagraph (1) or as subparagraph (2) if only dispensing. (1) Medication preparation room or area (a) This room or area shall be under direct or indirect (example, camera) visual control of the nursing staff. (b) This room or area shall contain the following: (i) work counter; (ii) Hand-washing station unless located within an operating room, Class 3 imaging, or sterile core of surgical department. Where hand-washing station is omitted in the sterile core, a hand sanitation dispenser shall be provided; (iii) Lockable refrigerator where refrigerated medications are used; (iv) Locked storage for controlled drugs; (v) Sharps containers, where sharps are used (c) Where a medication preparation room or area is used to store one or more self-contained medication dispensing units, the room shall be designed with space to prepare medication when the self-contained medication-dispensing unit(s) is present. (d) Where a medication preparation room is used to compound sterile preparations, it shall meet the requirements in USP-NF General Chapter <797> "Pharmaceutical Compounding-Sterile Preparations.""¶
(ff) Amend subsection 2.1-3.8.10.1 to read: "Ice-making equipment shall be of the self-dispensing type."¶
(gg) Amend paragraph (1) in subsection 2.1-3.8.12.3 to read: "(1) Hand-washing station."¶
(hh) Amend paragraph (2) in subsection 2.1-4.1.2.3 to read: "(2) Additional hand-washing stations shall be provided within 20 feet of each workstation where specimens or reagents are handled."¶
(ii) Amend subparagraph (1)(a) in subsection 2.1-4.1.2.5 to read: "Terminal sterilization is not required for waste that is incinerated on-site or when services for regulated medical/bio-hazardous waste disposal services will be contracted through a vendor."¶
(jj) Add paragraph (2) in subsection 2.1-4.1.8.1 to read: "(2) Refrigeration for storage of reagents, controls and patient specimens as necessary."¶
(kk) Add paragraph (3) in subsection 2.1-4.2.3.1 to read: "(3) Pharmacy clean/sterile compounding rooms accessed from an ante room need not comply with Table 1.2-4: Minimum Design Room-Average Sound Absorption Coefficients." ¶
(ll) Amend subsection 2.1-4.2.8.7 to read: "A hand-washing station(s) shall be provided within each separate room where open medication is prepared for administration except where prohibited by OAR chapter 855, division 045; USP 797 or USP 800. Where a hand-wash station is prohibited in the compounding room, a hand-wash station(s) shall be provided in an anteroom."¶
(mm) Amend paragraph (2) in subsection 2.1-4.3.2.4 to read: "(2) Clean/sterile medical/surgical supply receiving room or area. A room or area shall be provided for receiving/unpacking clean/sterile supplies received from outside the department or facility. This room or area may not be located inside clean storage."¶
(nn) Amend paragraph (1) in subsection 2.1-4.4.2.1 to read: "(1) This area shall be large enough to accommodate the following: (a) Washer/extractor(s). Washers/extractors shall provide a temperature of at least 160 degrees Fahrenheit for a minimum of 25 minutes or include use of a chemical disinfectant. (b) Dryer. (c) Supply storage. Storage shall be provided for laundry supplies. (d) Any plumbing equipment needed to meet the temperature requirements in Section 2.1-8.4.2.5(4) (Water temperature)."¶
(oo) Add subparagraphs (1)(b) through (1)(e) in subsection 2.1-5.2.1.3 to read: "(b) Wall base shall be integral and coved with the floor, tightly sealed to the wall, and constructed without voids that can harbor insects. (c) The regulated waste storage spaces shall have lighting and exhaust ventilation, be safe from weather, animals and unauthorized entry. (d) Regulated waste management shall be in accordance with the requirements of OAR chapter 333, division 056. (e) Refrigeration requirements for such holding facilities, if provided, shall comply with local and state regulations."¶
(pp) Amend subsection 2.1-5.3.1.2 to read: "Environmental services room provisions. Environmental services room shall be a minimum of 35 square feet. Each environmental services room shall be provided with the following: (1) Service sink or floor-mounted mop sink; *(2) Provisions for storage of supplies and housekeeping equipment; (3) Hand-washing station or hand sanitation dispenser."¶
(qq) Amend paragraph (2) in subsection 2.1-7.2.2.1 to read: "(2) Corridors used for stretcher and gurney transport shall have a minimum corridor or aisle width of 6 feet (1.83 meters). This requirement is not applicable to birth centers (see 2.4-7.2.1.1) or renal dialysis centers (see 2.10-3.2.1.5)."¶
(rr) In subsection 2.1-7.2.2.8:¶
(A) Amend subparagraph (1)(b) to read: "(b) The number and placement of hand sanitation dispensers shall be determined by an infection control risk assessment (ICRA)."¶
(B) Amend subparagraph (3)(b) to read: "For newly constructed or newly installed countertops that require a

substrate, marine-grade plywood (or an equivalent material) with an impervious seal shall be required. Existing countertops shall be fully sealed/caulked and in good repair."(C) Add paragraph (8) to read: "(8) Mirrors are not permitted at scrub, clinical or other staff use hand-wash stations, with the exception of staff toilets."¶
(ss) Add paragraph (4) in subsection 2.1-7.2.2.11 to read: "(4) All imaging facilities and radiation producing equipment installations must comply with OAR chapter 333, divisions 100 through 123, and be licensed by the Oregon Health Authority, Radiation Protection Services program."¶
(tt) Add subsection 2.1-7.2.2.15 to read: "Work Surfaces. Work areas. Where a work space, work area, work counter, or work surface is provided, it shall have a minimum of 4 square feet (.37 square meter) of contiguous clear surface for each person programmed to work in the space at the same time. A mobile cart meeting these requirements shall be permitted."¶
(uu) Add subparagraphs (6)(a)(ix) through (xii) in subsection 2.1-7.2.3.1 to read: "(ix) Protective environment rooms; (x) Bathing and toilet rooms; (xi) Soiled workrooms and soiled hold rooms; (xii) Environmental services room; (xiii) Pharmacy clean and anterooms."¶
(vv) Add subparagraph (1)(c)(ix) in subsection 2.1-7.2.3.2 to read: "(ix) Bathing and toilet rooms."¶
(ww) Add paragraph (4) in subsection 2.1-8.2.1.2 to read: "(4) Extended Stay Centers".¶
(xx) Amend subsection 2.1-8.7.1 and add paragraph (2) to read: "(1) Where an outpatient facility is located on more than one floor or on a floor other than an entrance floor at grade level, at least one elevator shall be provided. (2) Installation and testing of elevators shall comply with the Oregon Elevator Code."¶
(yy) Add subsection A2.1-8.7.1 to read: "Consideration should be given to dedicating and separating elevator types by function, such as those for the public, patients, staff, and materials (for example, clean versus soiled flows), as the diverse uses affect both operational efficiency and cross-contamination and infection control issues."¶
(zz) Amend subsection 2.1-8.7.5.1 and add paragraph (2) to read: "(1) Elevator call buttons and controls shall not be activated by heat or smoke. (2) Each elevator, except those for material handling, shall be equipped with an independent keyed switch for staff use for bypassing all landing button calls and responding to car button calls only."¶
(aaa) Amend section 2.2-3.8.11.3 to read: "A clean workroom may be shared with other clinical services in the same building, in accordance with state and federal regulations."¶
(bbb) Amend subsection 2.2-3.10.2.2 to read: "This patient toilet room shall be permitted to serve waiting areas in clinics with five or fewer examination rooms."¶
(ccc) Amend paragraph (1) to subsection 2.2-4.3.3.1 to read: "(1) Provision of an area instead of a room shall be permitted to meet the requirements in sections 2.1-4.3.3.1 (A room for breakdown...) and 2.1-4.3.3.2 (A room for on-site storage...). Breakdown area may not be located in clean workroom or clean storage."¶
(ddd) Amend subsection 2.2-5.2.3 to read: "Location of storage for hazardous waste (red bag trash) and sharps shall be behind a closed door. An exam room shall not be used for cumulated storage of hazardous waste and sharps."¶
(eee) Amend subsection 2.4-1.2 to read: "Functional Program. See section 1.2-2 and 2.1-1.2 (Functional Program) for requirements."¶
(fff) Amend subsection 2.4-2.2.4 to read: "Privacy. Windows or doors within a normal sightline that would permit observation into the room shall be designed for mother and newborn privacy. See 2.1-3.1.2 (Patient Privacy) for additional requirements."¶
(ggg) Amend subsection 2.4-2.2.6 to read: "Bathrooms. Each birthing room shall have direct access to a private bathroom that meets the requirements in 2.1-3.10.2 (Patient Toilet Room(s)) and includes the following:"¶
(hhh) Amend subsection 2.4-2.2.6.1 to read: "Hand-washing station. See Section 2.1-7.2.2.8 (Hand-washing stations) and Section 2.1-8.4.3.2 (Hand-washing station sinks) for requirements."¶
(iii) Amend subsection 2.4-2.2.6.3 to read: "Shower or tub. See Section 2.1-8.4.3.3 (Showers and tubs) for requirements."¶
(jjj) Add subsection 2.4-2.2.7 to read: "Documentation and Charting. Accommodations for written or electronic documentation shall be provided in the birthing room or at a nurse station. See Section 2.1-3.8.3 (Documentation Area) for requirements."¶
(kkk) Amend subsection 2.4-2.8.7 to read: "Hand-Washing Stations. Hand-washing stations shall be located in, next to, or directly accessible to staff work area(s) and not through a door."¶
(lll) Amend subsection 2.4-2.8.10.2 to read: "Ice shall be served from self-dispensing ice-makers."¶
(mmm) Amend subsection 2.4-2.8.11 to read: "Clean Workroom or Clean Work Area. A clean work area or clean workroom shall be provided in accordance with Section 2.1-3.8.11 (Clean Workroom or Clean Supply Room)."¶
(nnn) Amend subsection 2.4-2.8.13.4 to read: "Emergency equipment storage. See Section 2.1-3.8.13.4 (Emergency equipment storage) for requirements."¶
(ooo) Amend subsection 2.4-2.8.14 to read: "Environmental Services Room. An environmental services room that meets the requirements in Section 2.1-5.3.1.2 (Environmental services room provisions) shall be provided for the

exclusive use of the birth center."¶
(ppp) Amend reference to subsections 2.4-4.1 - 2.4-4.3 to read: "2.4-4.1 - 2.4-4.2 Reserved".¶
(qqq) Add subsection 2.4-4.3 to read: "Sterile Processing".¶
(rrr) Add subsection 2.4-4.3.1 to read: "Facilities for On-Site Sterile Processing. Where sterile processing is performed on-site, see Section 2.1-4.3 (Sterile Processing) for requirements."¶
(sss) Add subsection 2.4-4.3.2 to read: "Support Areas for Birthing Centers Using Off-Site Sterile Processing. For Birthing Centers where sterile processing services are provided off-site, see Section 2.1-4.3.3 (Support Areas for Outpatient Facilities Using Off-Site Sterile Processing) for requirements."¶
(ttt) Add paragraph (3) in subsection 2.4-4.5.2.1 to read: "(3) Shall meet the requirements of the Oregon Food Sanitation Rules OAR 333-150-0000."¶
(uuu) Amend subsection 2.4-6.2 to read: "Public Areas. Public areas shall be provided in accordance with Section 2.1-6.2 (Public Areas)."¶
(vvv) Amend subsection 2.4-7.1 to read: "Building Codes. The birth center shall be permitted to fall under the business occupancy provisions of applicable life safety and building codes. Building design and construction shall comply with local, state, and federal guidelines."¶
(www) Amend subsection 2.4-7.2 to read: "Architectural Details and Surfaces. See Section 2.1-7.2 (Architectural Details, Surfaces, and furnishings) for requirements."¶
(xxx) Amend section 2.4-8 to read: "Building Systems. See Section 2.1-8 (Building Systems) for requirements."¶
(yyy) Amend subsection 2.4-8.3.1 to read: "Lighting. (1) The birthing room shall provide lighting capable of providing at least 70 foot-candles in the delivery and newborn care area(s). (2) Exam light(s) shall be provided for each birthing room."¶
(zzz) Amend subsection 2.4-8.7 to read: "Elevators. Where elevators are provided, elevator cars shall have minimum inside dimensions of 5 feet 8 inches (1.73 meters) wide by 7 feet 6 inches (2.29 meters) deep. Installation and testing of elevators shall comply with the Oregon Elevator Code."¶
(aaaa) Amend paragraph (1) in subsection 2.5-3.2.3.1 to read: "(1) A dedicated triage space. The triage space or bay shall be a minimum 80 square feet."¶
(bbbb) Amend subsection 2.5-3.2.3.3 to read: "Hand-washing station. The triage area(s) shall be directly accessible to a hand-washing station(s) that complies with Section 2.1-3.8.7 (Hand-Washing Station). Hand-wash stations shall be provided in each triage room if rooms are provided."¶
(cccc) Amend subsection 2.5-3.3.3.1 to read: "Visual observation of all traffic into and within the unit shall be provided from the nurse station through direct or indirect visual observation."¶
(dddd) Amend subsection 2.7-1.2.3 and add paragraph (2) to read: "Shared Services. (1) If the outpatient surgery facility is part of an acute care hospital or other medical facility, services shall be permitted to be shared to minimize duplication as acceptable to authorities having jurisdiction. (2) If the facility is an ASC: An ASC is a distinct entity and must be separate and distinguishable from any other health care facility or office-based physician practice. Medicare-certified ASCs are subject to specific requirements related to sharing spaces with another health care facility or office-based physician practice. An ASC that is Medicare-certified must be distinct from any other health care facility or office-based physician practice as required in 42 CFR 416.2 and 42 CFR 416.44(a)(2) and (b)."¶
(eeee) Add subsection 2.7-3.1.1.5 to read: "Areas in the outpatient surgery facility. (1) Unrestricted area: Any area of the surgery facility that is not defined as semi-restricted or restricted. These areas shall include a central control point for designated personnel to monitor the entrance of patients, personnel, and materials into the semi-restricted areas; staff changing areas; a staff lounge; offices; waiting rooms or areas; pre- and postoperative patient care areas; and access to procedure rooms (e.g., endoscopy procedure rooms, laser treatment rooms). Street clothes are permitted in these areas. Public access to unrestricted areas may be limited based on the facility's policy and procedures. (2) Semi-restricted area: Peripheral areas that support surgical services. These areas shall include storage for equipment and clean and sterile supplies; work areas for processing instruments; sterile processing facilities (if on-site sterile processing is provided); hand scrub stations; corridors leading from the unrestricted area to the restricted area; and entrances to staff changing areas, pre- and postoperative patient care areas, and sterile processing facilities. The semi-restricted area is entered directly from the unrestricted area past a nurse station or from other areas. Semi-restricted areas have specific HVAC design requirements associated with the intended use of the space (see Part 3: ANSI/ASHRAE/ASHE 170: Ventilation of Health Care Facilities). Personnel in the semi-restricted area shall wear surgical attire and cover all head and facial hair. Access to the semi-restricted area shall be limited to authorized personnel and patients accompanied by authorized personnel. (3) Restricted area: A designated space contained within the semi-restricted area and accessible only through a semi-restricted area. The restricted area includes operating and other rooms in which operative or other invasive procedures are performed. Restricted areas have specific HVAC design requirements associated with the intended use of the space (see ANSI/ASHRAE/ASHE 170: Ventilation of Health Care Facilities). Personnel in the restricted area shall wear surgical attire and cover head and facial hair. Masks shall be worn when

the wearer is in the presence of open sterile supplies or of persons who are completing or have completed a surgical hand scrub. Only authorized personnel and patients accompanied by authorized personnel shall be admitted to this area."¶
(ffff) Add paragraphs (1) and (2) to subsection 2.9-3.2.1 to state: "(1) The endoscopy procedure room shall meet the requirements in Section 2.1-3.2.2 (Procedure Room) as amended in this section. (2) Where monolithic ceilings are provided in Endoscopy Procedure Rooms, the NRC standards listed in Table 1.2-4 are not required."¶
(gggg) Amend 2.9-3.10.3.2 to read: "Provisions shall be made for securing patients' personal effects. Individual, lockable storage shall be provided."¶
(hhhh) Add subsection 2.10-1.1.4 to read: "Fire suppression sprinkler systems are required in Medicare certified dialysis facilities housed in multi-story buildings construction Types II(000), III(200), or V(000), as defined in the 2012 edition of NFPA 101 Life Safety Code, Table 21.1.6.1, and those housed in high-rise buildings over 75 feet in height."¶
(iiii) Amend subsection 2.10-3.1 to read: "Examination Room. Where an exam room is provided, it shall meet the requirements in Section 2.1-3.2.1 (Examination room)."¶
(jjjj) Add subsection 2.10-3.2.1.4 to read: "Emergency Equipment. Emergency cart and equipment storage shall be located close to the patient treatment area, readily accessible by staff, and not located in an exit path. Emergency equipment shall also comply with 2.1-3.8.13.4 (Emergency equipment storage)."¶
(kkkk) Add subsection 2.10-3.2.1.5 to read: "Emergency transport of patient. Corridors, doorways, and stairways serving the unit shall be sized to allow at least one exit route for emergency medical personnel to transport a patient by stretcher to an ambulance. The identified corridor(s) shall be 44 inches minimum clear and any doors within the identified route shall have a minimum 42 inches door leaf width."¶
(llll) Add subsection 2.10-3.2.1.6 to read: "Patient Scale. Provide dedicated space for a patient scale."¶
(mmmm) Amend subsection 2.10-3.2.4 to read: "Patient Privacy. Space shall be available to accommodate provisions for patient privacy including when patients are examined or treated and body exposure is required. Privacy must be provided for the use of a bedpan or commode during dialysis, initiating and discontinuing treatment when the vascular access is placed in an intimate area, for physical exams, and for sensitive communications. There shall be sufficient numbers of privacy screens or other methods of visual separation available and used to afford patients full visual privacy when indicated."¶
(nnnn) Amend subsection 2.10-3.2.5.1 to read: "Hand-washing stations shall be provided in accordance with Section 2.1-3.8.7 (Hand-Washing Station). (1) Hand-washing stations shall be trimmed with fittings that are operable without use of the hands. Note: wrist blade controls are not considered to be operable without the use of the hands. (2) Exception: Home training room hand-wash stations may be trimmed with residential style controls."¶
(oooo) Add subsection 2.10-3.2.6 to read: "Body Fluid Disposal Sink".¶
(pppp) Add subsection 2.10-3.2.6.1 to read: "A fluid disposal sink shall be provided in each hemodialysis treatment area or room. Sink design including signage and location shall be constructed to prevent cross-contamination of the hand washing stations."¶
(qqqq) Amend subsection 2.10-3.3.2.3 to read: "Separate sink with identifying signage that it is for fluid disposal".¶
(rrrr) Add subsection 2.10-3.3.2.4 to read: "Emergency nurse call".¶
(ssss) Amend subsection 2-10-3.4.1 to read: "Airborne Infection Isolation (AII) Room. If the ICRA calls for an airborne infection isolation (AII) room, an AII rooms shall be provided."¶
(tttt) Amend subsection 2.10-3.4.1.3 to read: "The AII room shall allow for direct observation of the patient by staff during treatment. Direct observation must include patient face and insertion point."¶
(uuuu) Add subsection 2.10-3.4.2 to read: "Isolation Room".¶
(vvvv) Add subsection 2.10-3.4.2.1 to read: "An isolation room shall be provided for Hepatitis B positive (HBV+) patients to prevent contact transmission of HBV+ blood spills and other body fluids. The room shall meet the following requirements: (1) Provides a door and walls that go to the floor, but not necessarily the ceiling, and allows for visual monitoring of the patient; (2) Accommodates only one patient; (3) A hand washing station; and (4) A separate sink shall be provided within the isolation room for fluid disposal. Sink design and location shall be constructed to prevent cross-contamination of the hand washing station."¶
(wwww) Add subsection 2.10-3.4.2.2 to read: "The isolation room shall have a minimum clear floor area of 120 square feet."¶
(xxxx) Add subsection 2.10-3.4.2.3 to read: "The isolation room shall allow for direct observation of the patient by staff from a patient care staff station. Direct observation must include patient face and insertion point."¶
(yyyy) Amend subsection 2.10-3.8.2.2 to read: "The nurse station(s) shall be no higher than 3 feet 8 inches, designed to provide direct visual observation of all dialysis patient care stations. Direct observation must include patient face and insertion point."¶
(zzzz) Amend subsection 2.10-5.2 to read: "Waste Management. See Section 2.1-5.2 (Waste Management) for

requirements. Hand-washing station or hand sanitizer shall be provided within or adjacent to biohazardous waste storage area."¶
(aaaaa) Amend reference to 2.10-6.3.1 - 2.10-6.3.2 to read: "2.10-6.3.1 Reserved".¶
(bbbbb) Add subsection 2.10-6.3.2 to read: "Interview Space. See Section 2.1-6.3.2 (Interview space) for requirements)."¶
(ccccc) Amend section 2.10-7 to read: "Architectural Details, Surfaces, and Furnishings. See Section 2.1-7 (Architectural Details, Surfaces, and furnishings) for requirements."¶
(ddddd) Add subsection 2.10-8.3.1 to read: "General. For electrical system requirements, see Section 2.1-8.3 (Electrical Systems) and additional requirements in this section."¶
(eeeee) Add subsection 2.10-8.3.2 to read: "Reserved."¶
(fffff) Add subsection 2.10-8.3.3 to read: "Emergency Electrical Power. (1) Provisions shall be made to allow connection to an alternate power source. The point of connection shall be immediately accessible to the exterior. The alternate power source shall provide on-going power for the lighting and continued provision of dialysis services. (2) Power may be provided by an on-site generator or by means of a hitching post for connection to a portable generator provided under contract by others. Hitching post, if provided, must be located to allow connection without the need to leave a door or doors open during use."¶
(ggggg) Add reference to subsections 2.10-8.3.4 - 2.10-8.3.5 to read: "Reserved."¶
(hhhhh) Add subsection 2.10-8.3.6 to read: "Electrical Receptacles. One of the eight required receptacles shall be a dedicated GFI circuit on emergency power for the dialysis machine. Hospital grade electrical outlets shall be provided for all dialysis equipment connections."¶
(iiiii) Amend subsection 2.11-3.2.1.1 to read: "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."¶
(jjjjj) Amend subsection 2.11-3.2.1.2 to read: "A staff assist device to communicate with other staff, internal or external, when assistance is needed. Integrated communication systems (such as Vocera) are acceptable."¶
(kkkkk) Amend subsection 2.11-3.2.4 to read: "Consultation Room(s) These rooms are used for one-on-one counseling or therapy."¶
(lllll) Amend subsection 2.11-3.2.4.2 to read: "Each consultation room shall include a staff assist device to allow staff to communicate with other staff members, internal or external, when assistance is needed. Integrated communication systems (such as Vocera) are acceptable."¶
(mmmmm) Amend subsection 2.11-3.2.5.2 to read: "Staff assist device. Each group room shall include a staff assist device to allow staff to communicate with other staff members, internal or external, when assistance is needed. Integrated communication systems (such as Vocera) are acceptable."¶
(nnnnn) Amend subsection 2.11-3.2.7 to read: "Seclusion Rooms are not allowed in outpatient psychiatric centers."¶
(ooooo) Amend paragraph (2) in subsection 2.11-3.2.8.2 to read: "(2) This toilet room shall be permitted to be shared by patients using other activity spaces."¶
(ppppp) Amend subsection 2.11-3.2.9 to read: "Electroconvulsive Therapy is not allowed in outpatient psychiatric centers."¶
(qqqqq) Amend subsection 2.11-3.8.8 to read: "Where provided, see section 2.1-3.8.8 (Medication Safety Zones) for requirements." ¶
(rrrrr) Amend subsection 2.11-3.8.9 to read: "Where provided, location of a kitchenette(s) by the large group room(s) shall be permitted." ¶
(sssss) Amend subsection 2.11-3.8.11 to read: "Clean Workroom or Work Area or Clean Supply Room or Area - Where an exam room is provided, a clean workroom or work area meeting the requirements of 2.1-3.8.11.2 (Clean Workroom) or a clean supply room or area meeting the requirements of 2.1-3.8.11.3 (Clean Supply Room) shall be provided. Use of an area instead of a room shall be allowed providing area is under direct staff supervision or that storage is lockable."¶
(ttttt) Amend subsection 2.11-3.8.12 to read: "Soiled Holding Room - Where an examination room is provided or when biohazardous waste is generated, a soiled holding room meeting the requirements of 2.1-3.8.12 (Soiled Workroom or Soiled Holding Room) shall be provided."¶
(uuuuu) Amend subsection 2.11-3.8.13 to read: "Where an exam room is included, patient wheelchair storage shall be provided in accordance with Section 2.1-3.8.13.3 (Wheelchair storage and parking space)."¶
(vvvvv) Amend subsection 2.11-5.2 to read: "Waste Management - See Section 2.1-5.2.1 (Waste Collection and Storage Facilities) for requirements. Section 2.1-5.2.1.3 only required when an examination room provided or biohazardous waste is generated."¶
(wwwww) Amend subsection 2.11-6.2.3.1 to read: "The waiting area shall be under staff control."¶
(xxxxx) Amend subsection 2.11-6.2.3.2 to read: "Where the outpatient psychiatric center has a dedicated pediatrics service, a separate, controlled area for pediatric patients shall be provided unless temporal separation

is provided between adult and pediatric services (not seen at same or possible overlapping times)."¶
(yyyyy) Amend subsection 2.11-7.1.2 to read: "Observation of all public areas, including corridors, shall be provided."¶
(zzzzz) Amend subsection 2.11-7.1.2.1 to read: "This can be accomplished by electronic surveillance."¶
(aaaaaa) Amend subsection 2.12-1.2.1.2 to read: "Support areas may be shared in accordance with state and federal regulations."¶
(bbbbbb) Add 2.13-1.1.1.4 to read: "This chapter shall not be reviewed for Class 1 imaging mobile/transportable medical units that are to be used for less than 180 calendar days in a consecutive 12-month period while the permanent equipment and imaging space is receiving renovation or replacement work. Interim life safety measures shall be implemented and made available for review and inspection upon request. Documents shall record the arrival date and removal date of the trailer. A copy of these record documents shall be with the trailer for duration of placement." ¶
(cccccc) Amend subparagraph (1)(b) in subsection 2.13-1.1.2.1 to read: "A single-patient exam room for specialty clinical services as described in Section 2.1-3.2 (Clinical Service Rooms)."¶
(dddddd) Amend subsection 2.13-1.3.7.4 to read: "Applicable local and state requirements. All imaging facilities installations must comply with OAR chapter 333, divisions 100 through 123, and be licensed by the Oregon Health Authority, Radiation Protection Services program."¶
(eeeeee) Amend subsection 2.13-3.1.2 to read: "All mobile/transportable medical units shall be provided with a hand-washing station in accordance with Section 2.1-3.8.7 (Hand-Washing Station). For Class 1 imaging units that are not already provided with a hand-washing station, a hand-sanitation dispenser shall be provided instead."
Statutory/Other Authority: ORS 441.060, ORS 413.042
Statutes/Other Implemented: ORS 441.060