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## State of Oregon: Inspection and Approval Process for the Construction of Healthcare Facilities

# Final Recommendations Report

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# Introduction

## Background

The Oregon Legislature, in the 2015 Regular Session, adopted Senate Bill 886, adding a requirement for the Office of the State Fire Marshal to cite and document specific laws, regulations, or rules when issuing a citation in the course of inspecting a building for fire safety. However, an original version of the bill would have gone much further, consolidating responsibilities for oversight of the inspection and approval of healthcare facilities within the Department of Consumer and Business Services.

Testimony from many external stakeholders brought legislative attention to the level of frustration with the current process, and to specific challenges that resulted at specific healthcare facilities.

## Overview of the Project

In November 2015 the Oregon Health Authority (OHA) retained Coraggio Group under a master contract for Business Process Engineering to provide an independent and objective analysis—and recommendations for improvement of—the process of inspections and approvals related to the construction or remodeling of healthcare facilities in Oregon. The challenge, as stated by OHA, is:

***Services of four state agencies—Department of Consumer and Business Services (DCBS), Oregon Health Authority (OHA), Department of Human Services (DHS), and Oregon State Police (OSP)—are involved in licensing and life safety code review when constructing or remodeling a health care facility, and a lack of coordination between the agencies can lead to inconsistent and untimely service. Additionally, there is a lack of a clear, formal and timely mechanism for resolving code conflicts and for disputed findings.***

The first half of the project timeline was spent collecting input from the various internal and external stakeholders, in order to build a good understanding of the overall process, including where specific challenges have been and where potential opportunities for improvement may lie.

The second half of the project focused on identifying improvements, benchmarking best practices, developing recommendations, soliciting input and submitting our final report. A draft model for the improved process was presented to stakeholders and agencies on January 19, 2016, which was further refined by input from agency representatives, stakeholders and customers. The following report details our approach and recommendations.



# 1 | Executive Summary

Early in the process, we defined a set of Outcome Considerations that our team would use as we thought about different options to improve the healthcare facility design and construction approval process in Oregon:

- › The solution should seek the greatest improvement with the least disruption
- › The solution should solve today’s ongoing problems, while preventing the recurrence of the problems of the past
- › The solution must serve many groups of people
- › The solution must strive to solve this problem without creating other problems
- › The solution should be proportional to the size of the problem
- › The solution should leverage existing capabilities
- › The solution should align incentives and disincentives to the desired outcome, in order to shape the behavior of all involved
- › The solution must continue to work, regardless of personnel changes

Keeping these principles in mind, we interviewed a number of external stakeholders and agency representatives, facilitated a dozen meetings involving those stakeholders and/or agency representatives, performed research to learn key facts about how analogous processes are run in the other 49 states, solicited written stakeholder feedback, and held numerous internal meetings where we deliberated amongst ourselves to find solutions that we believe best balance the various factors we considered.

## Recommendations

We believe that all of these recommendations should be adopted in an expedient manner, particularly given the two-year timeframe we have recommended for review of measures of success. However, recognizing that our recommendations are not binding, we have organized the recommendations into four themes, which are listed in the order of their importance. In other words, if the state were to choose only one theme to implement, we would recommend beginning with theme one—but our sincere hope is that the state and its representatives will embrace and implement all four themes. These themes and recommendations are summarized in the table below, but are described in much greater detail in Section 2: Detailed Recommendations.

<b>Theme</b>	<b>Specific Recommendations</b>
<b>Improve Customer Service and Accountability</b>	<ul style="list-style-type: none"><li>› Make OHA responsible for ensuring that the process runs well, and accountable for its success</li><li>› OSFM personnel should once again perform NFPA 101 plans review and offer a sufficient number of site visits during construction on CMS-track projects</li><li>› Form a “Healthcare Unit” that collocates plan review and inspection personnel</li><li>› Institute oversight committee with stakeholder and agency representatives</li><li>› Develop clear protocols for different-sized projects</li></ul>

<b>Reduce Conflicts Through Reduction of Redundancy</b>	<ul style="list-style-type: none"> <li>› Begin effort to align specific code sections to specific agency responsibility in order to reduce the number and frequency of code conflicts</li> <li>› Create an ad-hoc workgroup to make detailed recommendations on code alignment</li> </ul>
<b>Implement Dispute Resolution Process</b>	<ul style="list-style-type: none"> <li>› Disputes should be handled collaboratively in a structured way, but if a collaborative decision cannot be reached, OHA/DHS should make the final decision as the CMS contract-holder</li> </ul>
<b>Develop Single Door for Customer Access</b>	<ul style="list-style-type: none"> <li>› Develop online single-door mechanism, utilizing an off-the-shelf package such as “e-permitting”, or by licensing the BCD system</li> </ul>

## Measures of Success

We have also recommended measures of success for three of our four themes, as noted in the table below. While these measures indicate *what* to measure, they do not recommend specific targets, the identification of which we have left to the proposed oversight committee.

<b>Theme</b>	<b>Measures of Success</b>
<b>Improve Customer Service and Accountability</b>	<ul style="list-style-type: none"> <li>› Plans review matches the survey for Facilities Planning and Safety (FPS)-owned items</li> <li>› Plans review matches the survey for Office of the State Fire Marshal (OSFM)-owned items</li> <li>› Customer satisfaction scores are consistently high for each project</li> <li>› Plans review happens within established timetables</li> <li>› Consistently low number of k-tags (CMS life safety citations) on construction-related items from an approved set of plans on any initial licensing survey</li> </ul>
<b>Reduce Conflicts Through Reduction of Redundancy</b>	<ul style="list-style-type: none"> <li>› Declining number of code conflict disputes</li> <li>› Increased processing speed for plans review</li> </ul>
<b>Implement Dispute Resolution Process</b>	<ul style="list-style-type: none"> <li>› Total number of disputes</li> <li>› Percentage of disputes resolved within 3-day standard</li> <li>› Percentage of disputes not resolved collaboratively</li> </ul>

## Additional Information

The implementation of these recommendations may have both resource and statutory implications. We have summarized our thoughts on both in sections 3 and 4 of this report.

Many options were considered in coming to this final set of recommendations, and many were rejected. Appendix A lists a few examples of options which were rejected, along with a summary of our reasoning for deciding against them.

In considering how Oregon might shape its future process, we looked to other states, conducting online research for all 50 states, and telephone interviews with state representatives of a handful of states we targeted whether for their specifically-relevant processes, or because of key similarities to Oregon. A summary of this research is included in Appendix B: Benchmarking.

## Acknowledgements

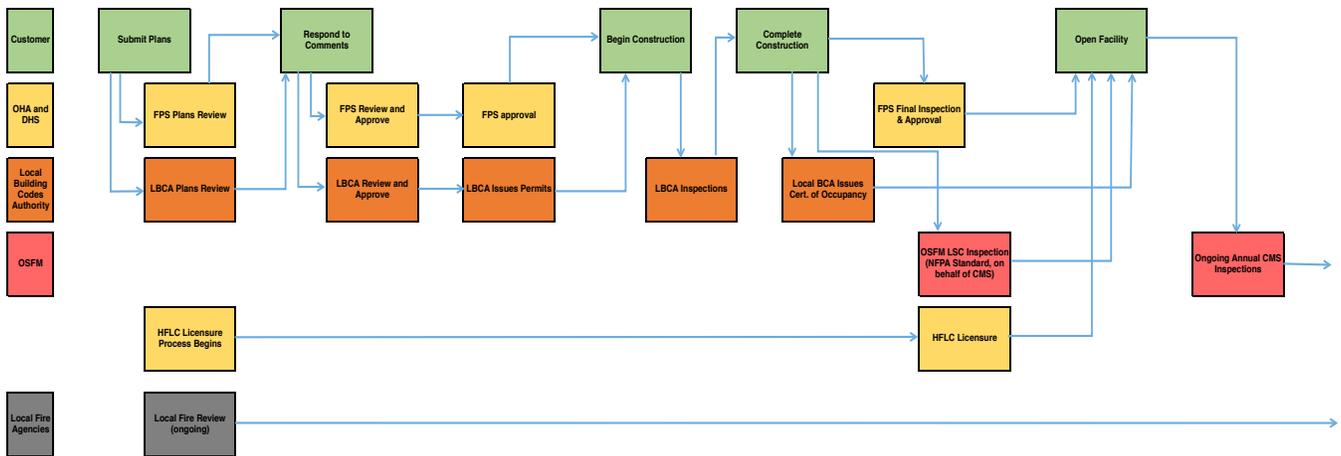
We wish to thank both the external stakeholders and the agency representatives who participated in this process for their willingness to share their expertise, for their patience with and dedication to the process, and for their frank assessments of our proposals. A complete list of these stakeholders can be found in Appendix C: Stakeholders.



# 2 | Detailed Recommendations

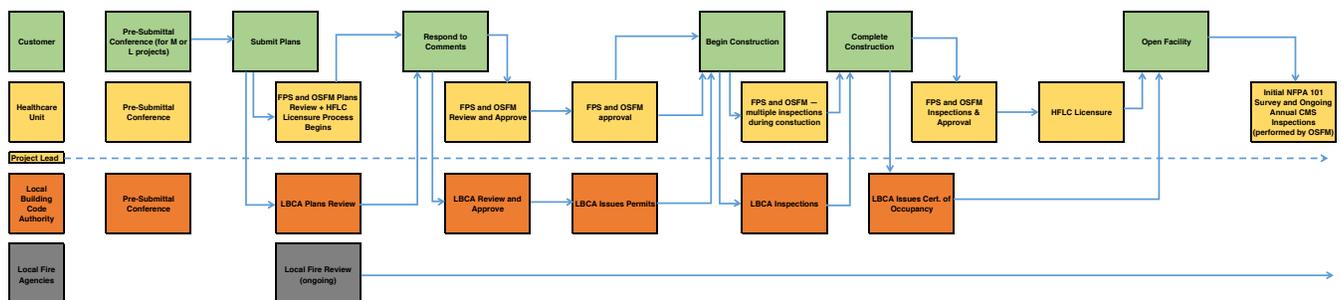
## Current Process

The graphic below represents a simplified overview of the current process, as we understand it. This graphic is generalized—that is, there are specific instances when the process varies from what is represented, and the timeline is not always as linear as represented. Nevertheless, the group of internal and external stakeholders agreed that this represents the current process at a high level. We used this “current state” as the basis for improvements throughout our process.



## Recommendations

Our recommendations, detailed on the following pages, would change the process chart considerably, as illustrated below, where the Office of the State Fire Marshal (OSFM) tasks have been rolled together with OHA and DHS into the Healthcare Unit line, OSFM site visits have been added during construction, a Project Lead continuity line has been added, and a pre-submittal conference phase has been added. Further, the changes we recommend will shape the way each of these steps is handled, will provide the ability to solve code disputes, put a higher degree of accountability on the agencies involved, and will separate out responsibilities for different portions of the various codes and regulations.



It is important to note that our recommendations are not binding. Although our recommendations have received some approval from the internal and external stakeholders we tested our ideas with, differing opinions have also been shared. Our hope is that this set of compromise recommendations will be taken up in earnest by the agencies involved, and that the customers of the system will see a rapid betterment of their experience.

We have grouped our recommendations into four themes:

- › Improve customer service and accountability
- › Reduce conflicts through reduction of redundancy
- › Implement dispute resolution process
- › Develop single door for customer access

These recommendations are aimed only at the approximately 200 healthcare design and construction projects in Oregon each year, and specifically exclude changes to any other design and construction projects in the state. In the detailed descriptions that follow, we have used bold text to indicate key points within the descriptions.

## Improve Customer Service and Accountability

Measures of Success:

- › Plans review matches the survey for FPS-owned items
- › Plans review matches the survey for OSFM-owned items
- › Customer satisfaction scores are consistently high for each project
- › Plans review happens within established timetables
- › Consistently low number of k-tags on construction-related items from an approved set of plans on any initial licensing survey

### **Make OHA responsible for ensuring that the process runs well, and accountable for its success**

We cannot stress enough how important it will be for OHA to take firm ownership of the process and demonstrate a customer-first mindset. This will begin with the assignment of a **project lead** to each project. This individual will be responsible for shepherding the project on behalf of the customer, ensuring that deadlines are met and that communication is smooth. From the customer's perspective, the project lead will be their main point of contact.

An additional responsibility of OHA's will be to provide better process information to customers, particularly those customers who haven't before been through design and construction of a healthcare facility in Oregon. This should include such information as key contacts, process overviews for different sizes and types of healthcare facilities, graphic representations of process flow, details of agency responsibilities to the customer (such as turnaround times), and a central repository of information related to the solutions to past code disputes. OHA should seek customer input and reference similar sources from other states as they design this **online information** source.

OHA, in its role as lead in this process, should have **accountability** for ensuring that the measures of success are met. All of these measures should be consistently collected and published on the OHA website. Should the agency fail to meet established benchmarks on any of these measures, the agency should be required to document the factors that contributed to missing the target, and publish those findings along with a detailed **process correction** that will prevent similar delays or errors in the future.

Additionally, when benchmarks are not met on a project, OHA should consider offering **remedies** that are of value to the customer, to the degree that legal authority to do so can be established.

### **OSFM personnel should once again perform NFPA 101 plans review and offer a sufficient number of site visits during construction on CMS-track projects**

It is our understanding that, since OSFM has ceased plans review on CMS-track projects, the incidence of citations at survey has climbed considerably. (We also understand that this is not the only factor contributing to that increase.) The re-establishment of NFPA plans review by OSFM personnel should minimize or eliminate the incidence of surprise citations at survey. We also recommend that OSFM and OHA **assume risk** when items are captured in survey that were not flagged during plans review and site visits during construction. It should be OSFM's goal to flag 100% of required changes early in the process, and never at survey. Therefore, assuming the risk for these items means that these agencies will be responsible to CMS for any discrepancies, rather than requiring changes from customers after construction is complete. In order to bear this responsibility, the plans review must be paired with a sufficient number of **site visits during construction** to ensure that deficiencies are identified before initial survey. However, should CMS themselves do a site visit to any facility and identify deficiencies that were not cited by state agencies, facility owners will still be required to make those changes—ultimately, our state agencies do not have jurisdiction over CMS.

The addition of plan review staff for NFPA 101 review will require resources, but it is left to the agencies to determine the extent to which these roles can be funded through reassignment of existing sources, or whether new sources are required.

OSFM should be **held accountable** for ensuring that plans review happens within established timetables, and for the number of k-tags on construction-related items from an approved set of plans on any initial licensing survey. Ideally, there should be no k-tags—that is, citations of life safety code deficiencies—excepting deviations made by the customer without approval of plans reviewers or inspectors. Both of these measures should be consistently collected and published on the OHA website. Should the agency fail to meet established benchmarks on any of these measures, the agency should be required to document the factors that contributed to missing the target, and publish those findings along with a detailed **process correction** that will prevent similar delays or errors in the future. Additionally, when benchmarks are not met on a project, OSFM should consider offering **remedies** that are of value to the customer, the degree that legal authority to do so can be established.

### **Form a “Healthcare Unit” that collocates plan review and inspection personnel**

Collocation is a proven method to increase team cohesion, communication, and alignment. Because plans and construction for healthcare facilities are reviewed by personnel from several agencies, collocation is a logical way to enhance customer-responsiveness and achieve greater alignment.

We recommend that OHA plan reviewers, OHA nurse surveyors, DHS Long Term Care facilities licensing personnel, OSFM plan reviewers, and OSFM inspectors **collocate at OHA’s Public Health offices** in Portland. The preference for a Portland location is two-fold: first, this will place the team geographically proximate to the greatest number of healthcare projects in the state, and second, will allow for accountable oversight from OHA’s Public Health division.

Because many of these individuals spend a significant amount of time in the field, we recommend that **two regularly-scheduled days per week** be set aside for collocation, and that a **weekly team meeting** be held on one of those days.

In order to maximize the amount of time these team members can be together, timing for surveys and inspections will need to be **coordinated for maximum efficiency**. The assigned project lead should be responsible for overseeing this coordination.

Although personnel on this team will remain **employees of their respective agencies**, OHA should be accountable for **oversight** of the unit, and ensuring that all timing and benchmarks are met on each project.

### **Institute oversight committee with stakeholder and agency representatives**

For the near term, a group outside of state government will need to be formed to give customers a voice in improving the process, and to hold all agencies involved accountable. We recommend a **nine-member temporary committee** be formed, with **five external stakeholder members** and **four agency members**. This committee should be formed by the Governor's office, and her office should appoint the **stakeholder chairperson**, who in turn will elect four additional stakeholder members. OHA, DHS, OSFM, and Building Codes Division (BCD) will each elect one representative to serve on this committee. OHA should be responsible for resources and staffing for the committee, as appropriate and necessary.

This committee should initially work closely with the agencies involved to **set specific benchmarks** for each of the measures of success identified in these recommendations, and should thereafter **meet quarterly** to review those measures of success and recommend ongoing process improvements to the agencies.

In March of 2018, this committee should make a **pass/fail determination** as to whether there has been material improvement in the process. This determination should be based upon the specific benchmarks agreed upon at the formation of the committee, and should, in the best judgment of the committee members, represent the true status of the process and its progress over the preceding two years.

If the committee deems that the process has materially improved, they may disband immediately, or choose a **one-time renewal of their charter** in order to provide additional oversight for a period of two additional years. This committee should **disband no later than March 2020**.

If the committee deems that the process has not materially improved according to the benchmarks set, we recommend that oversight of the process be **transferred to BCD** in a manner similar to that initially proposed in SB886, though the specifics of this recommendation should be **determined by the committee at that time**, as other factors may need to be considered, and other options considered. In this case, the committee may disband immediately after making this recommendation, or choose a one-time renewal of their charter to provide oversight for the transition, disbanding no later than March 2020.

### **Develop clear protocols for different-sized projects**

We recommend establishing a **tiered set of protocols** that will address different sizes of healthcare projects, and that these protocols be very clearly documented and shared on the OHA website as part of the online information portal recommended above.

OHA should lead a process to group projects into three categories (Small, Medium, and Large), based either on square footage or project cost estimates. For each size category, a specific matrix should be created that indicates agency responsibility, frequency, and turnaround time expectations for each stage of the design and construction process, including:

- › Pre-application
- › Design
- › Permitting/Plans Review
- › Construction
- › Occupancy
- › Post Occupancy

One specific item we recommend is that **pre-application meetings** be offered for medium and large projects. This meeting would include the owner team, OSFM, OHA/DHS, and the local building code authority, and should occur during the schematic design phase. By aligning the design team with the agencies early on, we believe many of the challenges identified may be reduced or eliminated.

## Reduce Conflicts Through Reduction of Redundancy

### Measures of Success:

- › Declining number of code conflict disputes
- › Increased processing speed for plans review

### **Begin effort to align specific code sections to specific agency responsibility in order to reduce the number and frequency of code conflicts**

We heard from stakeholders and agency representatives alike that there are certain areas where Oregon Administrative Rule requirements, OSSC codes and NFPA 101 codes are in conflict, or can be interpreted to be in conflict. In order to provide a long-term remedy that will prevent confusion and delays on construction projects, we recommend that a process to **delineate responsibility for these regulations** begin as soon as possible.

There are two main methods that can be considered for achieving a **delineation between OSSC and NFPA 101**. Either:

- › Determine which building systems will be governed by OSSC and which will be governed by NFPA 101, aligning agency responsibility to specific portions of the code accordingly, and/or
- › Use NFPA 101 as the governing code when any conflicts occur between OSSC and NFPA 101

Three other states (Georgia, Kentucky, and Vermont) have undertaken similar efforts, and their outcomes may be useful as a template for application in Oregon.

Additionally, there are challenges that arise from conflicts or interpreted conflicts between either OSSC or NFPA 101 codes and the healthcare-specific regulations that FPS reviews for. A similar effort should be undertaken to **ensure that FPS is only reviewing for items that are not covered by either OSSC or NFPA 101**, which may require some adjustments to Oregon Administrative Rules. In addition to focusing the scope of FPS's review, a hierarchy of codes should be implemented where NFPA 101 codes override OSSC codes, which in turn override any FPS regulations. Should there be specific structural regulations that OHA or DHS deems critical to the healthcare function of these buildings, they should pursue changes to the OSSC in order to raise those standards to meet the need.

### **Create an ad-hoc workgroup to make detailed recommendations on code alignment**

We also recommend that an **ad-hoc stakeholder workgroup** be formed to make more detailed recommendations on code alignment and to design the process by which these codes can be delineated both in the immediate future, and on an ongoing basis as codes are updated. We recommend that this workgroup be formed from among the external stakeholders who have been involved in this process, and those stakeholders should also pull in expertise from OHA, DHS, OSFM, and BCD as needed. OHA should be responsible for resources and staffing for the workgroup, as appropriate and necessary.

This workgroup should be given **six months to come to a set of recommendations** that will be made to the leads of the functional departments affected: OHA's Facilities Planning & Safety (FPS), DHS's Office of Licensing and Regulatory Oversight, DCBS's Building Codes Division (BCD), and the Office of the State Fire Marshal (OSFM).

It is important to note that these recommendations only need to apply to the approximately 200 healthcare projects per year, and they need not change state building codes. What they will change—for healthcare projects—is which *portions* of the code local building code reviewers are required to review, effectively narrowing their scope on those projects. This brings the added benefit of decreasing review time by removing redundant portions of the review.

## Implement Dispute Resolution Process

### Measures of Success:

- › Total number of disputes
- › Percentage of disputes resolved within 3-day standard
- › Percentage of disputes not resolved collaboratively

### **Disputes should be handled collaboratively in a structured way, but if a collaborative decision cannot be reached, OHA/DHS should make the final decision as the CMS contract-holder**

We recommend the formation of a **three-person dispute-resolution team** with representatives from OHA, OSFM, and BCD. Because of the need to have a standing team that can respond quickly to disputes, we have specifically recommended BCD to play the advisory role on this team, speaking on behalf of local building code authorities. This does not imply that the local building code authority should be cut out of the loop on these disputes. On the contrary, BCD should work closely with them to ensure that their point of view is represented, and they may be included in the discussions of the team if necessary. However, because we are working to eliminate conflicts between the different codes, having the consistent high-level view of the OSSC that BCD can bring to this team is critical to its success.

To minimize expensive delays of construction projects, this team should be prepared to turn around responses to disputes within three business days.

There will be some **limits** to this team's responsibility. First, this team should handle disputes pre-certificate of occupancy (or pre-notice of substantial completion) only. Once the building is completed, licensed by

OHA/DHS, and certified by CMS, this dispute resolution team has no jurisdiction. Further, if the team fails to agree on a resolution collaboratively within three business days, OHA or DHS, as the contract holder with CMS, should make the **final decision**.

As with the management of the overall process, OHA should be responsible for ensuring the ongoing efficacy of this committee by being **accountable** for the identified measures of success stated above.

For each dispute that goes through this process, OHA should document online the specifics of the conflict and its resolution. This **ongoing database** should be maintained and updated as codes change, and should pre-empt the need for the dispute resolution team if a specific challenge recurs.

## Develop Single Door for Customer Access

### **Develop online single-door mechanism, utilizing an off-the-shelf package such as “e-permitting”, or by licensing the BCD system**

Although the healthcare unit will be collocated, a customer would still be required to submit plans to multiple agencies at the beginning of a healthcare project. We envision that an **electronic permitting system** would allow for a **single electronic submittal** of plans, and that the distribution of those plans to the relevant agencies could be managed on the agency side. For the customer, this would provide “single door” access for healthcare projects, and would also save the significant costs of printing multiple sets of plans.

This online portal should provide **process transparency** for the customer, and include **accountability mechanisms** for agency timelines. This portal should also be connected to the upgraded online information source recommended above, supporting customers of the system with better access to information about the process.

There are several commercially-available systems that could serve this function, and these could be implemented as a stand-alone solution. Alternatively, OHA may choose to pay a license fee to BCD to use their e-permitting system.

This solution would require a capital investment and would take significant time to implement. Therefore, while work may begin on this project in the near future, it is important to note that **no other recommendations should be postponed** based on the timetable of this recommendation. Rather, this e-permitting system should be developed *while* all other changes are implemented.



# 3 | Resource Considerations

Forming a Healthcare Unit and implementing new systems to improve the customer experience will require additional resources. At the same time, the reduction of redundancy in plans review should provide some resource relief. While it would be ideal if these changes could be implemented through realignment of resources—rather than the addition of new resources—the agencies will need to determine the most efficient and cost-effective way to implement each of these changes.

Specific areas of note include:

- › The **formation of a Healthcare Unit** will simply consolidate multiple roles into one location. However, in order to adequately oversee each project, the deployment of **project leads** may require additional resources, though the reduction of redundant plan review may relieve enough staff time to accommodate this change. Oversight of the unit can possibly be accomplished through the existing supervisory structure of FPS. Administrative support for organization of schedules, particularly for the efficient scheduling of inspections, and staffing to support weekly meeting organization are additional possible needs. In our discussions with the agencies, OHA estimated that the additional work required implied the addition of a coordinator role, and possibly the elevation of a plans reviewer to a supervisory role.
- › The **re-introduction of plans review for NFPA 101 codes** will require additional staff with specialized training. The Office of the State Fire Marshal estimates that two FTE plans reviewers will be required. Unlike the survey, plans review is not paid for by CMS, so these resources will either need to be re-assigned within state government, or new sources of funding will need to be identified.
- › The **formation of an oversight committee** will require OHA resources to staff and support quarterly meetings.
- › A **tiered set of protocols** for different sizes of projects may result in additional resources being applied to larger projects, but may also result in fewer resources being applied to smaller projects.
- › The addition of a **pre-submittal conference** will require staff time from OHA/DHS and OSFM (as well as the local building code authority). On the other hand, we believe that the efficiencies gained from this early communication should balance the additional effort.
- › The **effort to re-align codes for healthcare projects** will require some staff time from agencies, both to staff and support the stakeholder workgroup, and to provide information and expertise to the workgroup.
- › The formation and ongoing staffing of the **dispute resolution team** will require some resources from OHA, DHS, OSFM, and BCD. However, if other recommendations are well-implemented, the frequency of use for this team should decline over time.
- › Finally, the **creation of a single-door online portal** will include both initial and ongoing capital expenses, as well as additional staff time to create and maintain the portal. In our discussion with agencies, it was thought that this effort, as well as some of the other temporary efforts above, might require a limited-duration staff addition.



# 4 | ORS/OAR Considerations

In assessing the current state of this process, and in designing our recommendations, we recognized that changes may need to be made to either Oregon Administrative Rules or Oregon Revised Statutes to improve the process. We recommend that the State carefully assess whether changes need to be made to the sections identified, and any other sections we may have missed. Primary concerns have to do with clarity of roles and responsibilities, as well as ensuring proper legal authority to perform all tasks under the revised process.

Rather than make specific legislative recommendations, we have identified the following sections of state statute and rule that should be considered, though this list may not be all-inclusive:

**There is a “loophole” in ORS 479.155, which gives BCD option to approve plans on behalf of OSFM.**

In the interest of refining the clarity of roles and responsibilities, we question whether the “loophole” in ORS 479.155 should be closed specifically for healthcare facilities, requiring that OSFM have responsibility for plans review related to CMS requirements. As it exists, this statute apparently gives BCD the option of reviewing plans on behalf of OSFM, which leaves two paths open rather than a single path with accountability measures.

**ORS 455.466 gives authority to DCBS to create case-specific conflict resolution paths, as well as plan review, permitting, and inspection services for “essential projects”.**

The use of this statute by DCBS could create an alternative path around the accountability measures that would be put into place as part of our recommendations. We question whether it might be in the best interest of the state to specifically exclude healthcare facilities from this statute.

**ORS 455.685 gives DCBS authority to receive building plans and marshal resources of other agencies, as appropriate, for review.**

Should this statute be applied to a healthcare project, it could create an alternative to the “Healthcare Unit” structure we have recommended. As with ORS 455.466, we question whether it might be in the best interest of the state to specifically exclude healthcare facilities from this statute.

**ORS 443.450 gives OHA and DHS authority to describe the “physical properties of the facility or home”**

In order to ensure that FPS is reviewing for only those items that are not covered by either OSSC or NFPA 101, we question whether this authority should be more carefully circumscribed in this section of the ORS.

**Any changes to fees would likely require changes to OARs**

Should it be determined that any of our recommendations will require an increase in fees, or should they provide for lower fees, those changes could be made through Oregon Administrative Rules, under the authority given in ORS 441.060.



# 5 | Appendix A: Alternative Analysis

During the course of the project, many alternative ideas were considered, but ultimately rejected by the Coraggio team. In the interest of transparency, we have included brief descriptions of some key alternatives not chosen, along with our reasoning for not choosing them:

## **Reorganization of Agency Responsibilities**

We considered, but decided against, the reorganization of responsibilities within an agency or across agencies. Our reasons for rejecting this alternative are:

- › The alignment of duties is best kept within the agency where they have the developed subject-matter expertise. We discussed the option of building new capabilities within or across agencies yet the time and resources required to effectively build those new capabilities jeopardizes the ability to deliver immediate process improvement benefits to the customers and stakeholders.
- › The alignment of pre-Certificate of Occupancy and post-Certificate of Occupancy responsibilities and viewpoints are best aligned within a single agency. The OSFM is currently contractually required to complete the survey (post C of O). The pre C of O plan review responsibilities are best aligned within the same agency to minimize the possibility of differing code interpretation—a key issue for customers and stakeholders.
- › The recommended changes will require a significant amount of process change within the existing agencies. We discussed the level of effort of the changes proposed in the recommendation and the ability of the agencies to successfully implement the changes. A reorganization within or across agencies would risk the ability to successfully implement the process changes that will deliver immediate benefit to the customers and stakeholders.

## **Process Ownership by a Non-Healthcare Agency**

We considered, but decided against, placing ownership of the process under a non-healthcare focused agency. Our reasons for rejecting this alternative are:

- › The ultimate purpose of the process is to ensure that the development and improvement of healthcare facilities focus on patient safety and are in line with CMS requirements. This focus on the safety of the healthcare patient is directly aligned to mission and objectives of OHA. Ownership of the process by a non-healthcare agency creates a misalignment of missions and objectives which may provide less focus on the safety of the healthcare patient.
- › Our benchmarking indicates that in 47 states the ownership of the process is by the state health agency. For those state where the process is not owned by the state health agency, it is owned by a general licensing agency – an agency that does not currently exist within the State of Oregon. In addition, in the three states where it is owned by the general licensing agency, the states reported a very low volume of healthcare projects.

### **Updating Oregon Structural Specialty Codes to align to NFPA 101 codes**

We considered, but decided against, asking BCD to continually update the OSSC to align to NFPA 101, for three main reasons:

- › Because CMS is using an outdated version of NFPA 101, alignment would either be to an outdated standard, or to a standard that is not being used for CMS certification surveys.
- › There is work occurring at the national level to better align the NFPA 101 codes with the International Code Council (ICC) codes upon which the Oregon codes are based. Therefore, Oregon's codes will better align with NFPA 101 over time, and we did not feel that the additional changes were warranted in the near term.
- › Because our recommendations, if enacted, are likely to effectively separate responsibility for enforcing different portions of code, rather than changing any codes, we didn't feel that the additional effort would be necessary.

### **Transferring the responsibility for reviewing to OSSC from local building code authorities to BCD in the case of healthcare projects**

We considered, but decided against, recommending that BCD perform the usual functions of a local building code authority for all healthcare projects.

- › The centralization of this function in state government may have gained some efficiencies at the state level, and we could have pulled the BCD review into the Healthcare Unit we recommended. However, this would have been very disruptive at the local level, complicating the cooperation that must occur between other local agencies involved when a facility is constructed, such as planning bureaus—interactions that local building code authorities are more accustomed to managing.

# 6 | Appendix B: Benchmarking

In conducting benchmark research, we undertook a dual approach: we collected data online for all 50 states, and we conducted personal interviews with agency representatives from a handful of states, with an eye towards choosing states that were both similar to Oregon and different from Oregon in terms of urban/rural divide, regulatory environment, and total population. Despite dozens of calls and emails, we were only able to gather responses directly from four states: Colorado, Georgia, Minnesota, and Utah.

The most significant finding of this research is how poor the analogous processes are in most states—Oregon is not alone in having challenges with the approval and inspection of healthcare construction. In many cases, the individuals sharing their state process with us were only marginally aware of other parts of the process beyond those for which they have direct line-of-sight. For most states, processes seem to be vague or convoluted, and state websites are generally information-poor. We were unable to identify any state where a single point of contact “owns” the process and has an overall view of the various activities that comprise the process.

## 50-State Research

On the issue of process ownership, we sought to identify whether the state health agency is responsible for licensing and certification. For 47 of the 50 states, this proved to be the case. The three exceptions include:

- Iowa, where the process is owned by the Department of Inspections and Appeals;
- Michigan, where the process is run by the Department of Licensing and Regulatory Affairs; and
- Vermont, where it is handled by the Division of Licensing and Protection.

Of those 47 states, 15 of them (32%) specifically place oversight of this process with the *public health* portion of their health agency.

State	Public Health Agency Owns Process?	Has Plans Review?	Informative and Useful Website?	Health Agency Plan Review AND Inspection?
Alabama	✓	✗	✗	Survey: Y; Plan Review: Y with Fee
Alaska	✓	✗	✗	Survey: Y; Plan Review: ??
Arkansas	✓	✓	✗	Y: Both
California	✓	✗	✗	Survey: Y; Plan Review: ??
Colorado	✓	✗	✗	
Connecticut	✓	✗	✗	N/A
Delaware	✓	✗	✓	
Florida	✓	✗	✗	
Georgia	✓	✗	✗	
Hawaii	✓	✗	✗	Survey: Y; Plan Review: ??
Idaho	✓	✗	✓	Survey: Y; Plan Review: ??
Illinois	✓	✗	✗	Survey: Y; Plan Review: ??
Illinois	✓	✗	✗	Survey: Y; Plan Review: ??
Iowa	✗	✗	✗	Survey: Y; Plan Review: ??
Kansas	✓	✗	✗	Survey: Y; Plan Review: ??
Kentucky	✓	✗	✗	Survey: Y; Plan Review: ??
Louisiana	✓	✗	✗	Maybe
Maine	✓	✓	✗	Y
Maryland	✓	✗	✗	?
Massachusetts	✓	✗	✗	Plan Review
Michigan	✗	✓	✓	Both
Minnesota	✓	✗	✗	
Mississippi	✓	✓	✗	Both
Missouri	✓	✗	✗	Inspection Y
Montana	✓	✓	✗	Both
Nebraska	✓	✓	✗	Both
Nevada	✓	✗	✗	Survey Y, review?
New Hampshire	✓	✗	✗	ish, plan review, survey?
New Jersey	✓	✗	✗	Survey Y, review ?
New Mexico	✓	✗	✗	
New York	✓	✗	✗	Survey Y, review ?
North Carolina	✓	✓	✗	Both
North Dakota	✓	✓	✗	Both
Ohio	✓	✗	✗	Survey: Y; Plan Review: ??
Oklahoma	✓	✗	✗	Survey: Y; Plan Review: ??
Oregon	✓	✗	✗	
Pennsylvania	✓	✗	✗	Survey: Y; Plan Review: ??
Rhode Island	✓	✗	✗	Survey: Y; Plan Review: ??
South Carolina	✓	✗	✗	Survey: Y; Plan Review: ??
South Dakota	✓	✗	✓	Survey: Y; Plan Review: ??
Tennessee	✓	✓	✓	Y: Both
Texas	✓	✗	✗	Survey: Y; Plan Review: ??
Utah	✓	✓	✓	Y: Both
Vermont	✗	✗	✗	Survey: Y; Plan Review: ??
Virginia	✓	✗	✗	Survey: Y; Plan Review: ??
Washington	✓	✗	✗	
West Virginia	✓	✗	✗	Survey: Y; Plan Review: ??
Wisconsin	✓	✓	✗	Y: Both
Wyoming	✓	✗	✗	Survey: Y; Plan Review: ??

It seems instructive that 94% of the states have chosen to place oversight of this process with the health agency. We believe that this speaks to the healthcare-specific challenges presented by this process, and the potential for health and safety repercussions should the process fail in any way.

Our 50-state research also indicated that only 11 states (22%) provide plans review related to the fire/life safety certification process required by the Centers for Medicare and Medicaid Services (CMS). One could assume that this often has to do with resource constraints, though in some cases the decision may have been made for other reasons.

We also did a subjective determination of how many states had clear, usable, and informative websites detailing this process, and found that only six states (12%) met our benchmark. This is perhaps the most surprising of our 50-state findings. Given the relatively low expense of putting detailed information on a website in a way that supports customer needs, we expected to see a greater prevalence of informative websites.

## State-Specific Research

### Plan Review Timeframe

The states we heard back from indicated that the initial plan review generally takes place in the two- to four-week timeframe. A notable exception is Minnesota, where they indicated a two-month turnaround is more common due to resource constraints.

### Wait Times for State/Local Inspections, Fire Safety, Certificate of Occupancy, State Licensure, CMS Certification

Our respondents did not always know the answer to this question (again, many only have a partial view of the process). Inspections and certifications appear to be based on a variety of actions performed by a wide range of people, hence the majority of people we asked were unable to quantify these wait times. Most of this work is done by local building authorities, the provider, or other internal health departments.

### Disputed Projects and Escalations During Constructions

Of the states that we spoke to, all estimated this rate to be very low, between five and ten percent of the overall project count. In Minnesota, they maintain a low percentage in part by funding a strong education program. This includes an annual conference that brings stakeholders together to discuss frequent issues and possible solutions, as well as to identify common conflicts that can lead to disputes or escalations. Colorado, on the other hand, cited their emphasis on holding the provider to high expectations for understanding the code and constructing accordingly. Similarly, Utah puts the onus on the provider and their team: "The healthcare provider will hopefully choose a competent architect and heap everything on the architect to figure out as far as the design review process and all of the rules."

### Percent of Projects Remediated after Completion

Most of our respondents indicated that the rate of remediation is very low—less than 10%. The one exception is Minnesota, where they estimate this rate to be as high as 75% (including minor changes). This seems to be an enforcement and reporting issue—change requests are not always called out in re-submitted plans, and in some instances disagreements on interpretation are ignored and construction continues without appropriate changes. Two factors may feed this issue: Minnesota has the largest number of annual projects of the states we talked to (240, by their estimate), and they are also resource-constrained. The high project volume, combined with personnel capacity issues, may combine to create this extraordinarily high rate of remediated projects.

Meanwhile, Colorado reported that they have only had one project that required remediation “in recent memory.” In this case, a dialysis facility had both life/safety and programmatic issues in meeting CMS requirements.

### **Healthcare Facility Design and Construction Process**

For the most part, responding states described a process that is very similar to Oregon’s. Plans submitted for review are reviewed by one to three agencies, depending on the state, and then are approved or returned with comments for changes. This part of the process was cited by Minnesota as being imperfect in that some changes go unnoticed or un-highlighted until the final inspection. At the same time, Minnesota also offers reviews with customers during the design phase, which should minimize the number of conflicts or changes requested at plan submittal.

Final inspection is initiated by the provider/architect team in all cases. The inspecting agency varies by state: some states use their Fire Marshal, while other states have the health agency person who did the plan review do the inspection. Interestingly, Minnesota indicated a stricter adherence to the letter of the law from the Health Department than from the Fire Marshal: “The [Fire Marshal] looks at things in the spirit of the law... but we have to look at the letter of the law.”

Throughout this part of the conversation, our interviewees showed a lack of awareness of the full process that they are part of. While they interact with a number of agencies, the intricacies of those agencies and the full scope of their processes and/or facility licensing responsibility is vaguely understood at best. Many of our questions were answered with, “I don’t know.”

### **Number of Agencies Involved; Contact Points**

The states from whom we received information indicated that anywhere from two to four agencies are involved in the healthcare construction process. No state had a single point of entry for customers: in every case, the customer is expected to shepherd their own project through the various agencies and sub-processes. Colorado, however, has created a liaison position with the intent of having them work with the Department of Public Safety and the provider to coordinate issues and handle disputes. This position is currently vacant. Georgia has a single point of contact for plan review within the Department of Community Health, but that contact person does not coordinate plan review with the other state and local agencies involved. Utah indicated an attempt at cross-agency collaboration, but indicated that it is inconsistent: “We try to copy our plan reviews to the local fire and building officials, but rarely do we hear back from them.”

### **Escalation Processes**

When these processes exist, they vary greatly. In some states, each agency handles their own disputes. Other states provide waivers for certain items to assist in maintaining the opening schedule for the facility. Others use a variance process that is more formal and time-consuming. In many cases, the escalation process does not seem to be spelled out explicitly. Minnesota is noteworthy, in that the final decision rests with the Health Department reviewing engineer, who will utilize the regional CMS office for final say when necessary. (This is in contrast to Oregon, where responses from the regional CMS office are neither timely nor specific.)

### **Code Conflicts**

Like Oregon, Utah’s building codes are based on the ICC codes, while the NFPA 101 code is the standard used by CMS: “This is a big issue... we enforce ICC codes as well as the local fire and building folks, so there will always be items we catch that the locals don’t and vice-versa.” Minnesota cited a similar ongoing conflict: “There is a huge difference between fire/life safety and [the] building code.”

Georgia, on the other hand, partitions the codes and all fire/life safety elements are put under the jurisdiction of the Fire Marshal and looked at solely through the lens of NFPA 101.



# 7 | Appendix C: Stakeholders

In December 2015 through March 2016, Coraggio collected input from a great many stakeholders, including those within the four agencies connected to this process (OHA, DHS, DCBS, and OSP) and external stakeholders who have an interest in the improvement of the process. Both groups were invited to a series of meetings, together and separately, and the recommendations contained in this report relate directly to ideas gathered from stakeholders.

External stakeholders were selected based on testimony before legislative committees related to SB886, or through email communications related to the issue. In some cases, external stakeholders were not responsive to our outreach early in the process, and contributed their input later in the process, mainly at the meetings. Other stakeholders joined at the very end of the process, either for the final stakeholder meeting, or for the written comment period. External stakeholders included the following:

<b>Name</b>	<b>Organization/Company</b>
Greg Alderson	House Speaker Office
Phil Bentley	Oregon Health Care Association
James Carlson	Oregon Health Care Association
Rocky Dallum	Tonkon Torp LLP
Inga Deckert	Oregon Building Officials Association
Elizabeth Edwards	City of Portland
Mike Eliason	Associated General Contractors
Steve Forster	Tualatin Valley Fire & Rescue/Oregon Fire Chiefs Association
Joe Greenman	Oregon Health Care Association
Ruth Gulyas	LeadingAge Oregon
Drew Hagedorn	Tonkon Torp LLP
LeeAnn Hastings	Oregon Association of Hospitals and Health Systems
Courtney Johnston	Pac/West communications
Brian Krieg	FocusPoint Communications
Kirsten Larson Adams	Associated General Contractors
Brian Noble	Sheet Metal Worker's International Association
Nicole Palmateer	Oregon Fire Chiefs Association
John Patterson	Jackson County Fire District #3 Fire Marshal/Oregon Fire Marshals Association
Nathan Phillips	Electrical Contractors Association – Oregon Pacific-Cascade
Dan Purgiel	LRS Architects
Doug Riggs	Elliott Bay Group/Oregon Ambulatory Surgery Center Association
Cindy Robert	American Institute of Architects, Oregon Chapter
Eric Schmidt	City of Gresham Community Development Department
Matt Stormont	Oregon Health & Science University
Ryan Tribett	Pac/West Communications
Michael A. Van Dyke	Deckert Jillions
Terry Whitehill	Portland Bureau of Development Services

Agency representatives invited to participate in this project include the following:

<b>Name</b>	<b>Organization/Company</b>
Heidi Moawad	Oregon Governor's Office
Jeremy Vandehey	Oregon Governor's Office
Lynne Saxton	Oregon Health Authority
Lillian Shirley	Oregon Health Authority
Dana Selover	Oregon Health Authority
Rosa Klein	Oregon Health Authority
Allyson Ford	Oregon Health Authority
Donna Keddy	Department of Human Services
David Allm	Department of Human Services
Pat Allen	Department of Business and Consumer Services
Mark Long	Department of Business and Consumer Services
Brett Salmon	Department of Business and Consumer Services
Jim Walker	Office of State Fire Marshal
Mike Trabue	Office of State Fire Marshal

We were able to identify a number of consistent themes in what we heard from these internal and external stakeholders. These themes form the basis of a common understanding between all the parties involved: where the process works well, where there are specific challenges, and where opportunities may lie for improvement.

# 8 | Appendix D: Stakeholder Comments

On March 17, we sent draft recommendations to stakeholders who had participated in the process, and asked them for written comments within one week. Many of the concerns expressed in these written comments have been addressed through changes to our recommendations.

Comments were received from the following individuals, and are listed here in the order received.

1. Dan Purgiel, LRS Architects
2. Inga Deckert, Deckert Jillions
3. Michael Van Dyke, Deckert Jillions
4. Matt Stortmont, Oregon Health & Science University
5. Nathan Philips, Integrated Electronic Systems
6. Phil Bentley, Oregon Health Care Association
7. Brian Krieg, FocusPoint Communications
8. Ryan L. Tribbett, PacWest Communications
9. John Patterson, Oregon Fire Marshal's Association

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## From: Dan Purgiel, LRS Architects

*To all*

*Attached are my suggested edits to the “Draft of Final Recommendation V6” emailed from Mathew 3/17/16. The edits also incorporate some suggestions from some of the customer stakeholders. Also attached is the other states examples of the referenced “splitting of the codes”.*

- › *The edits add some missing portions from the consensus recommendations from the customer stakeholder meeting held on 3/9/16.*
- › *The 10 original draft points are also reorganized and placed under 4 new general summary recommendations. These 4 recommendations are placed in a sequential order with the original draft detailed bullets under.*

*(Dan Purgiel’s (DCP) suggestions for edits (in ~~cross-out~~ and underline text) to the “**Draft of Final Recommendation V6**”.*

- *The 10 previous bullet points are reorganized under 4 general recommendations and placed in sequential order. The actual old numbers are removed for clarity. The tier 1 and 2 headers are also removed and incorporated into the 4 general headers.*
- *The largest edit is moving the old number 5 to the new number 2 (Remove Redundancy) and adding more concise language for agency understanding. This subject was discussed in detail and agreed on by consensus at the 3/9/16 customer stakeholder meeting.*
- *The other major edit is that old number 8 has more detail added that was agreed on at the 3/9/16 meeting and is moved under the new major heading number 3 (Develop Better Processes).*

Recommendations

## **1. IMPROVE CONTROLLING GOVERNMENT AGENCY CUSTOMER SERVICE AND ACCOUNTABILITY**

### **A. OHA is accountable for ensuring that the process runs well**

- Provides better up-front information
  - Utilizes customer input to design basic web info
- Assigns a “project lead” to each project
  - Manages/ensures communications between all agencies involved and the customer
- Accountability
  - Measures of success
    - Plans review matches survey for FPS-owned items
    - Plans review matches survey for OSFM-owned items
    - Customer satisfaction scores
  - Remedies
    - Public and transparent listing of tracking against measures of success
    - Requirement for documented remedy to prevent same error in future
    - Consider one of the following for projects where the team doesn't meet established measures of success:
      - Future fee waiver
      - “Fast Pass” for a future project

### **B. OSFM personnel ~~do~~ to re-engage conducting NFPA 101 plan review required for CMS-track projects**

- Includes site visit(s)
- OSFM to assume risk related to alignment of plan review with survey
- Accountability
  - Measures of success
    - Turnaround time on plan review
    - Number of k-tags on construction-related items from approved set of plans on initial licensing survey
  - Remedies
    - Public and transparent listing of tracking against measures of success
    - Requirement for documented remedy to prevent same error in future
    - Consider one of the following for projects where the team doesn't meet established measures of success:
      - ~~Future Fee waiver~~
      - “Fast Pass” ~~for a future project~~

### **C. Form “Healthcare Unit” that collocate plan review and inspection personnel**

- Form Health Care review unit that integrates plan review and inspection functions. Collocate OHA plan reviewers, OHA nurse surveyors, DHS Long Term Care facilities licensing personnel, OSFM plan reviewers, and OSFM inspectors at Public Health offices in Portland. (Leave OSSC reviews and approvals under local building department control.)
- Consider the following or modify per core agency function:
  - Collocation to occur on at least 2 regularly-scheduled days per week
  - Collocation to include at least one weekly “team meeting”
  - Timing for surveys and inspections to be coordinated for maximum efficiency

- OHA to be accountable for oversight of the unit, while personnel will remain the employees of their respective agencies

## **2. REDUCE CONFLICTS BY REDUCING REGULATION REDUNDANCY**

### **A. Implement more institutionalized delineation between the key enforcing agencies regulations by creating distinct “lines in the sand” between the regulations. (OHA/ DHS, OSFM, and BCD)**

- Reduce as much redundancy as possible between the key agencies and their respective regulations. “Reducing the redundancy” concept will help minimize conflicts between enforcing agencies and customers that have been cited by various parties during the stakeholders’ meetings.
  - BCD/ OSSC and OSFM/ NFPA101:
    - Begin effort to “split” the codes OSSC and NFPA 101 in order to reduce the number and frequency of code conflicts. Review and consider or combine some aspects of splitting NFPA 101/ IBC for CMS facilities (hospitals and nursing facilities) as other states such as Georgia, Kentucky, and Vermont have accomplished (Attached). Either:
      - Determine which building systems will be governed by OSSC and which will be governed by NFPA 101, aligning agency responsibility to specific portions of the code accordingly, and/ or
      - Use NFPA 101 as the governing code when any conflicts occur between OSSC and NFPA 101.
      - Review the Kentucky example as possibly being the most applicable option for Oregon.
  - OHA/DHS:
    - OHA/ DHS regulations should generally not include any regulation that is covered in the OSSC, NFPA 101, accessibility, OFC (fire code), mechanical, plumbing, or electrical codes. (Example: Current DHS nursing regulations require 44” clear doors, where both NFPA 101 and OSSC (IBC) require 41.5” doors. It is most likely the case that the 44” DHS requirement came from older 1990’s OSSC and NFPA 101 requirements that DHS has not kept up with and has not changed.)
    - If there is redundancy in OHA/ DHS requirements compared to the other stated codes above, then OHA DHS regulations should include a scoping hierarchy that NFPA 101 rules, then BCD family of codes, then OHA/DHS.
    - It is suggested here that if OHA/ DHS does prefer to override any other state code requirements, that OHA/ DHS should go through the normal state code revision and adoption process in those respective codes for implementing their other special requirements.
- Form temporary citizen committee to design process and make recommendations on code alignment
  - Committee to leverage expertise of BCD, OHA/DHS, and OSFM as necessary to inform decision-making
  - Six months to deliver recommendations to BCDS Director

## **3. DEVELOP BETTER PROCESSES FOR REVIEWS AND APPROVALS**

- A. **Develop protocols for during design, permitting, construction, and post construction between the four departments (BCD, OHA/ DHS, and OSFM) different-sized projects**
- Divide projects review and approvals into three (S, M, L) categories and develop matrix guide and recommendations for the four departments and the various phases of a project as noted below.
    - Detail timing and turnaround time for plan reviews and associated meetings
    - Detail timing and number of inspections during construction
  - **Pre App:** Offer pre-application meetings on an opt-out basis
    - Applies only for projects designated under “medium” or “large” protocols
    - Meeting includes owner team, OSFM, OHA/DHS, and local building code authority
    - Should occur during the Schematic Design phase
  - **During Design:** Offer “near end of design” review for medium and large projects (DHS/OSFM).
  - **Permitting:** Re-establish and create protocols for permitting reviews and associated response times.
  - **During Construction:** Establish recommendations and guides for intervals of during construction reviews and approvals based on the size of the project (OSFM).
  - **Move In:** Establish recommendations and guides for occupancy reviews and approval and associated response times (DHS/OSFM).
  - **Post Occupancy:** Establish recommendations and guides for post occupancy reviews and approvals (OSFM).
- B. **Develop online single-door mechanism, utilizing an off-the-shelf package such as “e- permitting”, or by licensing the BCD system**
- Longer-term opportunity that should not delay the implementation of other recommendations
  - Include accountability mechanisms
  - Offer better up-front information
- C. **Specifically exclude healthcare facilities from the “loophole” in ORS 479.155, which gives BCD option to approve plans on behalf of OSFM.**
- Only necessary to specifically exclude healthcare building types
    - Clarity of roles and responsibilities

#### **4. IMPLEMENT CONFLICT RESOLUTION PROCESS AND OVERSIGHT IMPROVEMENT**

- A. **Disputes to be handled collaboratively in a structured way, but if collaborative decision cannot be reached, OHA/DHS to make final decision as the CMS contract-holder**
- Form three-person dispute-resolution team with representatives from OHA, OSFM, and BCD
    - BCD to play an advisory role on this team, to speak on behalf of local building code authorities, providing broad and consistent view of the Oregon Structural Specialty Codes in dispute resolutions
  - This team will handle disputes pre-certificate of occupancy (or “notice of substantial completion”) ONLY
  - Specific timeframe for dispute review — 3 business day turnaround for disputes
  - Accountability
    - Measures of success

- Total number of disputes
- Number of disputes resolved within 3-day standard
- Percentage of disputes not resolved collaboratively
- Remedies
  - Ongoing online documentation of disputes and their resolution, as basis to prevent future disputes

**B. Institute oversight committee with stakeholder and agency representatives**

- Committee to include seven participants, with four stakeholder members and three agency members
- Committee chairperson to be an external stakeholder selected by Governor’s office; stakeholder members to be chosen by committee chairperson; agencies to put forward their own representatives—one representative each from OHA, DHS, and OSFM
  - BCD not assigned to this committee in order to maintain their neutrality
- Committee to meet quarterly to review measures of success and recommend process improvements to agencies
- Committee to be charged with making pass/fail determination of material improvement in the process by March 2018
  - Committee disbands after making recommendation. However, if continuing effort is required, committee may elect a one -time renewal of its charter for two additional years.
  - Committee disbands no later than March 2020

**C. If no material improvement by March 2018, recommend reverting to the framework proposed envisioned by SB886, placing management of the process under BCD.**

- Recommendation made by oversight committee

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**From: Inga Deckert, Deckert Jillions**

I am submitting the below comments on behalf of the Oregon Building Officials Association (OBOA) in response to the most recent recommendation for the healthcare construction process. We would like to thank you for the work you and your staff have done thus far in this process and for working with all of the interested stakeholders. Although we feel generally comfortable with the most recent draft, we do have some concerns around clarity and potential outcomes in the event there are no “material improvements.” We’ve outlined our comments more specifically below.

**Generally:**

- We believe it is important to clarify in the final recommendations that the issues being discussed in regards to plan reviews are intended to relate **solely** to CMS facilities and not more broadly to any other type of building. Providing this clarity is critical in ensuring the intent of this workgroup is clearly stated and will not be construed over broadly.

**Sections 1 & 2:**

- Can you provide a definition for a “documented remedy”? We believe it is important to clearly define some of these outcomes to ensure compliance is feasible.

- We are concerned with the potential “fee waiver” and “fast pass” options listed in both sections 1 and 2 of the recommendations. Our concern surrounds the legality of providing either of these two options in the event established standards are not met. Has the legal authority to do so been outlined?

**Section 4:**

- OBOA believes that in addition to the Building Codes Division (BCD) playing an advisory role, BCD should also be responsible for updating the building codes when discrepancies are found between NFPA 101 and the building codes. OBOA remains committed to participate and collaborate in any way towards this end to ensure clarity between conflicting codes.

**Section 5:**

- We suggest that BCD be required to work collaboratively with all stakeholder groups to update the OSSC when conflicts are identified to align the OSSC with NFPA 101.

**Section 7:**

- What is defined as a “material improvement”? We believe that specific criteria should be defined in order to determine whether there has been a “material improvement.” Additionally, the person(s) determining whether there has been such an improvement should be clearly identified as well.
- We are concerned with deciding on a defined outcome in the event there have not been “material improvements” by March of 2018. Instead, we suggest revisiting the issue as a whole and using the the past two years of experience as a foundation for creating a new solution to the issue. Through that new process, we could leverage new ideas based on what we learned over the previous two years. Simply pre-determining an alternative outcome this early in the process would revert us back to where we began in the 2015 legislative session.

**Section 10:**

- In addition to excluding healthcare facilities from ORS 479.155, we believe ORS 455.466 and ORS 455.685 should also be excluded. If the intent is to prevent BCD from approving plans on behalf of OSFM, including the aforementioned ORS’s would further that intent and only allow BCD such authority, with respect to healthcare facilities, if the local jurisdiction requests BCD’s assistance with the process.

Thank you again for soliciting our comments to the draft and if you have any questions or comments, please feel free to contact me at your convenience.

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**From: Michael Van Dyke, Deckert Jillions**

I am submitting the below comments on behalf of the City of Hillsboro in response to the most recent recommendation for the healthcare construction process. We are very appreciative of all the work you and your staff have done over the past several months. Your inclusion of the relevant stakeholders has allowed for a robust conversation and finished product that we feel is very close to agreeable. While we are mostly comfortable with the most recent draft, we do have some concerns that we have outlined more specifically below.

**Section 4:**

- The City believes the three-person dispute-resolution team would be best served if the Building Codes Division (BCD) was required to work in conjunction with local building officials in their advisory role. Because Oregon is such a diverse state with no one part of the state being like any other, a requirement that BCD consult with local building officials during their advisory role would allow for more complete and area specific information.

Furthermore, the system and circumstances by which local jurisdictions operate can vary depending on the size and location. Therefore, consultation between BCD and local building officials would provide a more comprehensive dispute-resolution process.

**Section 7:**

- Our initial concern involves the phrase “material improvement.” Without defined standards and a designated person(s) to make such a determination, we’re concerned with this being the basis for a pre-determined secondary outcome. If this section remains in the final recommendations, we would advocate for defined standards and agreement amongst the stakeholders as to who will do the evaluation in March 2018.
- We are also concerned with including a pre-determined secondary outcome in the final recommendations. Recommending the management of the program go to the BCD in the event there are no “material improvements” would discount any new knowledge we gain during the preceding two years. Instead, we suggest revisiting the issue as a whole and using the past two years of experience as a foundation for creating a solution to the issue that is reflective of current circumstances. Through that new process, we could leverage new ideas based on what we learned over the previous two years. Simply pre-determining an alternative outcome this early in the process would revert us back to where we began in the 2015 legislative session.

Thank you for taking our comments into consideration. If you have any questions or would like further clarification, please feel free to contact me at your convenience.

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**From: Matt Stortmont, Oregon Health & Science University**

(In response to Dan Purgiel's memo)

Dan,

Thank you for re-working these recommendations into a series of workable steps. Your edited document is more clearly formatted and includes additional stakeholder comments than was previously captured by the consultant.

From an hospital owner's perspective, having a more clear line of authority regarding regulatory building code, fire code and dispute resolution is critical to making healthcare services more affordable for Oregonians.

I support these recommendations and look forward to working with the state agencies to put into place outcomes from this work.

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**From: Nathan Philips, Integrated Electronic Systems**

Subject: Re: Feedback Requested: Coraggio Draft Final Recommendations for Healthcare Construction Process

Here are my comments for the record:

My comments are offered as owner of Integrated Electronic Systems, a NECA member electrical contractor in Oregon that frequently performs installations in licensed healthcare facilities. In addition, I personally have a twenty-five year history of involvement in code development both in Oregon and nationally. I served for thirteen years on the Oregon Electrical and Elevator Board, three as chair, have chaired the stakeholder committee for adoption of the Oregon Electrical Specialty Code for the last five code cycles and am currently chair of the NEC Code Making Panel 5 (grounding and bonding). Furthermore, I am also a developer of medical properties, some of which contain licensed facilities, and have experience with the system from the perspective of the owner.

As a customer of the system that has struggled for years to receive timely, consistent and reasonable plan review and enforcement on licensed healthcare facility projects, we feel that our concerns were not listened to in this process. The

proposed solution does not adequately address the problems in the existing system that lead to the development of SB 886. It suffers from the same problem that currently exists of having multiple agencies with no clear administrative and management lines of authority.

As a representative of the electrical industry in this process, we submit that the problem in the electrical area, including fire alarm, is not a lack of a coordinated set of codes. In other areas of the industry we frequently work with multiple codes that are not fully coordinated with no significant difficulties. In addition, as an owner working with project architects, we have also not experienced coordination of building and safety codes to be the cause of the difficulties we encounter. The cause is inconsistent enforcement due to a lack of clear interpretive oversight and poor performance due to a lack of accountability. We believe that the codes need to align with national standards and national training programs and oppose efforts to create a set of building codes that are unique to Oregon.

We are also concerned that the proposed solution introduces local government into the interpretive process in a manner that increases the level of confusion and lack of accountability which makes the problem worse. The proposed appeals panel and process is unclear and gives final decision making authority over construction code interpretation to a non-construction agency further increasing the lack of clarity and accountability. As paying customers we don't believe the proposed solution is satisfactory and will continue to talk to our elected representatives through our own construction industry joint stakeholder group to develop an acceptable solution.

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**From: Phil Bentley, Oregon Health Care Association**

(in response to Matt Stortmont's email)

Based on our review of the notes from Matthew [Landkamer, of Coraggio Group] and the reworked version from Dan [Purgiel, of LRS Architects], we agree that Dan's suggested changes are a better reflection of the discussion at our last meeting. We look forward to working on continuing to move this process forward and implementing these changes.

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**From: Brian Krieg, FocusPoint Communications**

Government Affairs Representative for:  
Plumbing & Mechanical Contractors Association of Oregon (PMCA)  
Sheet Metal and Air Conditioning Contractors National Association – Columbia Chapter (SMACNA)

I have only very recently obtained a copy of the 4 page document of draft revised recommendations regarding building inspection of healthcare facilities that your organization has put together. On behalf of SMACNA and PMCA, the State's two largest trade associations representing the plumbing, sheet metal and HVAC subcontractors we would like to raise a few concerns about the recommendations and some of the directions taken. Not having been identified as stake holders, though having testified on the original legislation, nor been apprised of the direction that this process has taken till the eleventh hour does not provide us much time to have considered the long term implications of the proposed changes – or provide a thorough response.

Our organizations are very supportive of building codes and their importance to public safety. Striving for consistent application, interpretation and enforcement of building codes across all impacted jurisdictions is an important goal for all involved – so that the public is kept safe. And so that industry can train for and do the job correctly.

Several key elements of concern are:

- Funding and staffing – can a firm and long term commitment be made and approvals for qualified staff be obtained. Our experience with multi agency teams has been mixed – especially when state budgets get tight.
- Having a dispute resolution process where BCD only has an advisory role on the team.

- Potentially adopting a code that pose other consequences for construction outside of the healthcare realm.
- Significant commitment to the enforcement of a selected code
- An oversight committee where the chairperson chooses the other stakeholders.
- BCD purposefully excluded from the from the oversight committee when three other agencies are included, two of which have little experience in construction and codes.
- What are the actual metrics for whether this new process makes a positive material difference?

The origin of SB 866 was not that there are code conflicts – it is in the appropriate timing and coordination between the various players who have enforcement and inspection roles. Fire and life safety are important parts of construction projects, but not the only parts. Oregon actually has one of the better code systems in the country, a system which currently provides for broad stakeholder input, integration of the various codes, processes for regular updating/adoption of codes, ways of adjusting codes so that codes do not end up in conflict and so that national codes can be adjusted to account for differences in Oregon’s unique laws, environmental/energy policies and climate. Our system is envied by fellow contractors in neighboring states. Many of our contractors and our labor partners volunteer significant hours to sit on the various state boards, providing great expertise in the code. The process outlined in your document seems to veer away from this – and poses concern to our industry.

In conclusion I would like to request to be added to the list of those being informed of this process. Thank you for this opportunity to comment.

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**From: Ryan L. Tribbett, PacWest Communications**

Subject: RE: Feedback Requested: Coraggio Draft Final Recommendations for Healthcare Construction Process

The National Electrical Contractors Association (NECA) participated in the Coraggio Group process with a unique perspective. Back in 2014, NECA convened a working group comprised of a broad cross section of healthcare facility owners and construction contractors. There was universal agreement among the group that problems arise due to the involvement of two separate Authority Having Jurisdictions (AHJs), which inevitably creates enforcement conflicts.

The state has no process to identify conflicting federal and state codes, and no formal plan on how to handle conflicts. As a result, when conflicts occur, contractors must wait for the State Fire Marshals and Building Officials to reach consensus. Those disputes do not always reach resolution in a reasonable timeframe, leaving contractors in the lurch with no clear direction how to proceed and unable to complete the project on time and on budget.

There are instances where State Fire Marshals have required costly design changes at the end of construction, despite having conducted their own plan review before construction began. In many cases, the State Fire Marshal’s new requirements have led to delayed completion, and, in some cases, changes required by the State Fire Marshal would put the facility out of compliance with the state building code.

Adding insult to injury, there have been several situations in the last few years where State Fire Marshals did not provide any written legal or codified basis for a specific required change, even when requiring contractors to build to a standard considered out of compliance with state codes.

NECA’s working group clearly understands that the Centers for Medicare and Medicaid Services (CMS) is a federal agency that issues construction requirements through the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), and we strongly support the intended purpose of those requirements: to provide building occupants safety from fire, smoke and panic. But we also understand that many of these responsibilities are duplicative with state building code enforced by officials authorized by the Building Codes Division (BCD), who are also responsible for protecting the health and safety of building occupants.

We understand that in Oregon, CMS partners with the Oregon Health Authority (OHA), and OHA in turn subcontracts with the Office of State Fire Marshal (OSFM) to enforce the federal CMS codes. Therefore, fire marshals play a role in approving final occupancy of healthcare facilities, alongside the traditional building official. However, due to the aforementioned inconsistencies with the State Fire Marshal's own standards and conduct, our group proposed a solution that would shift the interagency agreement in order to reposition the CMS Fire and Life Safety contract from State Police/State Fire Marshal to BCD for plan review and final inspection.

Unfortunately, the policy concept we envisioned was not what was reflected in SB 886, as introduced.

NECA and its working group agreed to temporarily suspend efforts to pass SB 886 during the 2015 session, based primarily on commitments from then-policy advisor Sean Kolmer to convene a process that would be industry-driven. While there was no guarantee that the solution fashioned by our working group would be the conclusion of the Kolmer-led group, we accepted in good faith that our framework would be the starting point for a process led internally by the Governor's office.

Unfortunately, the process that has been conducted by the Coraggio Group was not industry-driven and spent more time discussing whether a problem existed or not, rather than real solutions. The fact is that NECA would have never agreed to suspend our legislative effort in 2015 if we had any indication the process would be agency driven. We believe the path suggested by the Coraggio Group does nothing more than perpetuate the status quo and will cost the private sector more money without improving service or safety. Somehow, this process resulted in a solution that will actually hurt the people we sought out to help.

I look forward to working with you all as we prepare legislation for the 2017 Legislative Session.

Thank you for considering this comment on behalf of the National Electrical Contractors Association.

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**From: John Patterson, Oregon Fire Marshal's Association**

Subject: Re: Feedback Requested: Coraggio Draft Final Recommendations for Healthcare Construction Process

Thank you for all the time and energy you and your company have put into this important topic. The Oregon Fire Chief's and Fire Marshal's Associations appreciate this opportunity to provide feedback on Coraggio's final recommendation. We believe the recommendations outlined will serve to clarify the processes by which essential fire and life safety requirements are addressed. Our customers are the people of Oregon. Their safety and the safety of responding firefighters is of paramount importance.

Please consider revising Tier 1 item 5 from *temporary citizen committee* to instead read *ad-hoc stakeholder committee*.

There may be confusion about who would make up a *citizen* committee. It appears the desired outcomes are to deliver recommendations within six months on how to design the process and make code alignment recommendations. An ad-hoc stakeholder committee may be better suited to these tasks.

The path forward and a framework is provided. Further specifics and detailed operations are better left for the Agencies to decide.

# 9 | Appendix E: Process

From December 2015 through March 2016, Coraggio collaborated with agency representatives, stakeholders and customers to seek solutions to improve the speed, coordination, and consistency of the Health Care Facility Construction Approval Process. During our process design discussions, we looked for opportunities for the four state agencies to integrate and align their process flows for the review and approval of health care facilities construction projects with the following design criteria in mind:

- › Must add value for customers
- › Must maintain health and safety for occupants
- › Must be adequately resourced
- › Must have defined timeframes
- › Must comply with federal regulations
- › Must include fair and equitable process without conflicts of interest
- › Must be transparent to the customer
- › Must define “where the buck stops”

Over the four months, Coraggio conducted the following activities with agency representatives, stakeholders and customers to understand the current state of the process, the root cause of problems, potential improvement opportunities and to co-create the future state design of the process:

- › Held immersion sessions with state agencies: OHA, DHS, BCD, OSFM
- › Reviewed testimony
- › Conducted stakeholder interviews – internal and external
- › Held session to co-create the current state value stream map and solicited agency, stakeholder and customer process improvement input
- › Drafted an interim report for review and feedback
- › Conducted targeted benchmarking research of all 50 states
- › Held agency meeting to review resource needs for proposed changes
- › Held agency meeting to review statute/rule impacts of proposed changes
- › Presented draft future state model to agency representatives to solicit additional input into the future state process
- › Presented draft future state model to stakeholders and solicited additional input into the future state process
- › Held additional stakeholder meeting to solicit additional feedback on recommendations
- › Drafted final report
- › Solicited and incorporated agency, stakeholder and customer feedback into the final report
- › Presented final future state in final report to agency representatives

During these activities, we kept the following outcome considerations in mind to guide the final recommendations:

- › The solution should seek the greatest improvement with the least disruption
- › The solution should solve today’s ongoing problems, while preventing the recurrence of the problems of the past
- › The solution must serve many groups of people
- › The solution must strive to solve this problem without creating other problems
- › The solution should be proportional to the size of the problem
- › The solution should leverage existing capabilities

- › The solution should align incentives and disincentives to the desired outcome, in order to shape the behavior of all involved
- › The solution must continue to work, regardless of personnel changes

# 10 | Appendix F: Terms List

In the interest of clarity, we have identified key terms and acronyms that have been used throughout the process, and in this document. Given that different participants in the process understand different meanings for some of these terms, we have identified here our intended meaning of the term as used here.

<b>Term</b>	<b>Intended Meaning</b>
BCD	Building Codes Division, a division of DCBS
CMS	Centers for Medicare and Medicaid Services
DCBS	Oregon Department of Consumer and Business Services
DHS	Oregon Department of Human Services
FPS	Facilities Planning and Safety, part of Oregon Health Authority's Public Health division
ICC	International Code Council
inspection	Physical inspection of construction, whether in-progress or completed
NFPA	National Fire Protection Association
OAR	Oregon Administrative Rules
OHA	Oregon Health Authority
ORS	Oregon Revised Statutes
OSFM	Office of the State Fire Marshal
OSSC	Oregon Structural Specialty Code
plans review	Review of architectural plans; verifies that the proposed construction, as designed, meets code requirements
survey	Physical inspection of construction, particularly that related to CMS certification
SB886	Adopted Senate Bill 886