Chapter 413 — Oregon Health Authority

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OREGON HEALTH AUTHORITY

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413.005 [Formerly 413.010; 1965 c.556 §21; 1973 c.651 §7; 2003 c.14 §184; repealed by 2005 c.381 §30]

OREGON HEALTH POLICY BOARD

413.006 Establishment of Oregon Health Policy Board. (1) There is established the Oregon Health Policy Board, consisting of nine members appointed by the Governor.

(2) The term of office of each member is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(3) The appointment of the board is subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

(4) Members of the board are entitled to reimbursement of per diem and travel expenses for their attendance at board meetings and subcommittee meetings as provided in ORS 292.495. [2009 c.595 §1]

413.007 Composition of board. (1) The Oregon Health Policy Board consists of individuals who:

(a) Are United States citizens and residents of this state;

(b) Have demonstrated leadership skills in their professional and civic lives;

(c) To the greatest extent practicable, represent the various geographic, ethnic, gender, racial and economic diversity of this state; and

(d) Collectively offer expertise, knowledge and experience in consumer advocacy, management of a company that offers health insurance to its employees, public health, finance, organized labor, health care and the operation of a small business.

(2) No more than four members of the board may be individuals:

(a) Whose household incomes, during the individuals' tenure on the board or during the 12-month period prior to the individuals' appointment to the board, come from health care or from a health care related field; or

(b) Who receive health care benefits from a publicly funded state health benefit plan.

(3) No more than four members of the board may be, during the individuals' tenure on the board or during the 12-month period prior to the individuals' appointment to the board, employed in a health care or health care related field.

(4) At least one member of the board shall have an active license to provide health care in Oregon and shall be appointed to serve in addition to the members offering the expertise, knowledge and experience described in subsection (1)(d) of this section. [2009 c.595 §4]

413.008 Chairperson; quorum; meetings. (1) The Governor shall select from the membership of the Oregon Health Policy Board the chairperson and vice chairperson.

(2) A majority of the members of the board constitutes a quorum for the transaction of business.

(3) The board shall meet at least once every month and shall meet at least once every two years in each congressional district in this state, at a place, day and hour determined by the board. The board may also meet at other times and places specified by the call of the chairperson or a majority of the members of the board, or as specified in bylaws adopted by the board. [2009 c.595 §5]

413.009 [Formerly 413.020; 1965 c.556 §22; 1967 c.204 §2; 1969 c.468 §4; 1973 c.651 §8; repealed by 2005 c.381 §30]

413.010 [Amended by 1961 c.620 §9; renumbered 413.005]

413.011 Duties of board. (1) The duties of the Oregon Health Policy Board are to:

(a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS 413.032 and all of the authority's departmental divisions.

(b) Develop and submit a plan to the Legislative Assembly by December 31, 2010, to provide and fund access to affordable, quality health care for all Oregonians by 2015.

(c) Develop a program to provide health insurance premium assistance to all low and moderate income individuals who are legal residents of Oregon.

(d) Publish health outcome and quality measure data collected by the Oregon Health Authority at aggregate levels that do not disclose information otherwise protected by law. The information published must report, for each coordinated care organization and each health benefit plan sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board:

(A) Quality measures;

(B) Costs;

(C) Health outcomes; and

(D) Other information that is necessary for members of the public to evaluate the value of health services delivered by each coordinated care organization and by each health benefit plan.

(e) Establish evidence-based clinical standards and practice guidelines that may be used by providers.

(f) Approve and monitor community-centered health initiatives described in ORS 413.032 (1)(h) that are consistent with public health goals, strategies, programs and performance standards adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and shall regularly report to the Legislative Assembly on the accomplishments and needed changes to the initiatives.

(g) Establish cost containment mechanisms to reduce health care costs.

(h) Ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by the expansion in health coverage, health care system transformations, an increasingly diverse population and an aging workforce.

(i) Work with the Oregon congressional delegation to advance the adoption of changes in federal law or policy to promote Oregon's comprehensive health reform plan.

(j) Establish a health benefit package in accordance with ORS 741.340 to be used as the baseline for all health benefit plans offered through the health insurance exchange.

(k) Investigate and report annually to the Legislative Assembly on the feasibility and advisability of future changes to the health insurance market in Oregon, including but not limited to the following:

(A) A requirement for every resident to have health insurance coverage.

(B) A payroll tax as a means to encourage employers to continue providing health insurance to their employees.

(L) Meet cost-containment goals by structuring reimbursement rates to reward comprehensive management of diseases, quality outcomes and the efficient use of resources by promoting cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations.

(m) Oversee the expenditure of moneys from the Health Care Workforce Strategic Fund to support grants to primary care providers and rural health practitioners, to increase the number of primary care educators and to support efforts to create and develop career ladder opportunities.

(n) Work with the Public Health Benefit Purchasers Committee, administrators of the medical assistance program and the Department of Corrections to identify uniform contracting

standards for health benefit plans that achieve maximum quality and cost outcomes and align the contracting standards for all state programs to the greatest extent practicable.

(o) Work with the Health Information Technology Oversight Council to foster health information technology systems and practices that promote the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.570 and align health information technology systems and practices across this state.

(2) The Oregon Health Policy Board is authorized to:

(a) Subject to the approval of the Governor, organize and reorganize the authority as the board considers necessary to properly conduct the work of the authority.

(b) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the board's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

(3) If the board or the authority is unable to perform, in whole or in part, any of the duties described in ORS 413.006 to 413.042 and 741.340 without federal approval, the authority is authorized to request, in accordance with ORS 413.072, waivers or other approval necessary to perform those duties. The authority shall implement any portions of those duties not requiring legislative authority or federal approval, to the extent practicable.

(4) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042 and 741.340 and by other statutes.

(5) The board shall consult with the Department of Consumer and Business Services in completing the tasks set forth in subsection (1)(j) and (k)(A) of this section. [2009 c.595 §9; 2011 c.9 §55; 2011 c.720 §125; 2012 c.38 §15; 2013 c.1 §55; 2013 c.681 §44; 2015 c.3 §42; 2015 c.243 §2; 2015 c.389 §6]

413.014 Rules. In accordance with applicable provisions of ORS chapter 183, the Oregon Health Policy Board may adopt rules necessary for the administration of the laws that the board is charged with administering. [2009 c.595 §6]

413.015 [Formerly 413.030; repealed by 1969 c.69 §8]

413.016 Authority of board to establish advisory and technical committees. (1) The Oregon Health Policy Board may establish such advisory and technical committees as the board considers necessary to aid and advise the board in the performance of the board's functions. These committees may be continuing or temporary committees. The board shall determine the representation, membership, terms and organization of the committees and shall appoint the members of the committees.

(2) Members of the committees who are not members of the board are not entitled to compensation, but at the discretion of the board may be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by them in the performance of their official duties, in the manner and amount provided in ORS 292.495. [2009 c.595 §8]

413.017 Public Health Benefit Purchasers Committee, Health Care Workforce Committee and Health Plan Quality Metrics Committee. (1) The Oregon Health Policy Board shall establish the committees described in subsections (2) to (4) of this section.

(2)(a) The Public Health Benefit Purchasers Committee shall include individuals who purchase health care for the following:

(A) The Public Employees' Benefit Board.

(B) The Oregon Educators Benefit Board.

(C) Trustees of the Public Employees Retirement System.

(D) A city government.

(E) A county government.

(F) A special district.

(G) Any private nonprofit organization that receives the majority of its funding from the state and requests to participate on the committee.

(b) The Public Health Benefit Purchasers Committee shall:

(A) Identify and make specific recommendations to achieve uniformity across all public health benefit plan designs based on the best available clinical evidence, recognized best practices for health promotion and disease management, demonstrated cost-effectiveness and shared demographics among the enrollees within the pools covered by the benefit plans.

(B) Develop an action plan for ongoing collaboration to implement the benefit design alignment described in subparagraph (A) of this paragraph and shall leverage purchasing to achieve benefit uniformity if practicable.

(C) Continuously review and report to the Oregon Health Policy Board on the committee's progress in aligning benefits while minimizing the cost shift to individual purchasers of insurance without shifting costs to the private sector or the health insurance exchange.

(c) The Oregon Health Policy Board shall work with the Public Health Benefit Purchasers Committee to identify uniform provisions for state and local public contracts for health benefit plans that achieve maximum quality and cost outcomes. The board shall collaborate with the committee to develop steps to implement joint contract provisions. The committee shall identify a schedule for the implementation of contract changes. The process for implementation of joint contract provisions must include a review process to protect against unintended cost shifts to enrollees or agencies.

(3)(a) The Health Care Workforce Committee shall include individuals who have the collective expertise, knowledge and experience in a broad range of health professions, health care education and health care workforce development initiatives.

(b) The Health Care Workforce Committee shall coordinate efforts to recruit and educate health care professionals and retain a quality workforce to meet the demand that will be created by the expansion in health care coverage, system transformations and an increasingly diverse population.

(c) The Health Care Workforce Committee shall conduct an inventory of all grants and other state resources available for addressing the need to expand the health care workforce to meet the needs of Oregonians for health care.

(4)(a) The Health Plan Quality Metrics Committee shall include the following members appointed by the Oregon Health Policy Board:

(A) An individual representing the Oregon Health Authority;

(B) An individual representing the Oregon Educators Benefit Board;

(C) An individual representing the Public Employees' Benefit Board;

(D) An individual representing the Department of Consumer and Business Services;

(E) Two health care providers;

(F) One individual representing hospitals;

(G) One individual representing insurers, large employers or multiple employer welfare arrangements;

(H) Two individuals representing health care consumers;

(I) Two individuals representing coordinated care organizations;

(J) One individual with expertise in health care research;

(K) One individual with expertise in health care quality measures; and

(L) One individual with expertise in mental health and addiction services.

(b) The committee shall work collaboratively with the Oregon Educators Benefit Board, the Public Employees' Benefit Board, the authority and the department to adopt health outcome and quality measures that are focused on specific goals and provide value to the state, employers, insurers, health care providers and consumers. The committee shall be the single body to align health outcome and quality measures used in this state with the requirements of health care data reporting to ensure that the measures and requirements are coordinated, evidence-based and focused on a long term statewide vision.

(c) The committee shall use a public process that includes an opportunity for public comment to identify health outcome and quality measures that may be applied to services provided by coordinated care organizations or paid for by health benefit plans sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board. The authority, the department, the Oregon Educators Benefit Board and the Public Employees' Benefit Board are not required to adopt all of the health outcome and quality measures identified by the committee but may not adopt any health outcome and quality measures that are different from the measures identified by the committee. The measures must take into account the recommendations of the metrics and scoring subcommittee created in ORS 414.638 and the differences in the populations served by coordinated care organizations and by commercial insurers.

(d) In identifying health outcome and quality measures, the committee shall prioritize measures that:

(A) Utilize existing state and national health outcome and quality measures, including measures adopted by the Centers for Medicare and Medicaid Services, that have been adopted or endorsed by other state or national organizations and have a relevant state or national benchmark;

(B) Given the context in which each measure is applied, are not prone to random variations based on the size of the denominator;

(C) Utilize existing data systems, to the extent practicable, for reporting the measures to minimize redundant reporting and undue burden on the state, health benefit plans and health care providers;

(D) Can be meaningfully adopted for a minimum of three years;

(E) Use a common format in the collection of the data and facilitate the public reporting of the data; and

(F) Can be reported in a timely manner and without significant delay so that the most current and actionable data is available.

(e) The committee shall evaluate on a regular and ongoing basis the health outcome and quality measures adopted under this section.

(f) The committee may convene subcommittees to focus on gaining expertise in particular areas such as data collection, health care research and mental health and substance use disorders in order to aid the committee in the development of health outcome and quality measures. A subcommittee may include stakeholders and staff from the authority, the Department of Human Services, the Department of Consumer and Business Services, the Early Learning Council or any other agency staff with the appropriate expertise in the issues addressed by the subcommittee.

(g) This subsection does not prevent the authority, the Department of Consumer and Business Services, commercial insurers, the Public Employees' Benefit Board or the Oregon Educators Benefit Board from establishing programs that provide financial incentives to providers for meeting specific health outcome and quality measures adopted by the committee.

(5) Members of the committees described in subsections (2) to (4) of this section who are not members of the Oregon Health Policy Board are not entitled to compensation but shall be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495. [2009 c.595 §7; 2015 c.3 §43; 2015 c.389 §2; 2019 c.3 §1]

413.018 [2009 c.595 §7a; repealed by 2015 c.829 §8]

413.019 [Formerly 413.040; 1967 c.116 §2; repealed by 2005 c.381 §30]

413.020 [Renumbered 413.009]

413.025 [Formerly 413.150; 1969 c.69 §6; repealed by 1981 c.784 §38]

413.029 [Formerly 413.190; repealed by 2005 c.381 §30]

413.030 [Amended by 1961 c.620 §10; renumbered 413.015]

413.031 [2009 c.595 §18; renumbered 413.101 in 2011]

OREGON HEALTH AUTHORITY

413.032 Establishment of Oregon Health Authority. (1) The Oregon Health Authority is established. The authority shall:

(a) Carry out policies adopted by the Oregon Health Policy Board;

(b) Administer the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.570;

(c) Administer the Oregon Prescription Drug Program;

(d) Develop the policies for and the provision of publicly funded medical care and medical assistance in this state;

(e) Develop the policies for and the provision of mental health treatment and treatment of addictions;

(f) Assess, promote and protect the health of the public as specified by state and federal law;

(g) Provide regular reports to the board with respect to the performance of health services contractors serving recipients of medical assistance, including reports of trends in health services and enrollee satisfaction;

(h) Guide and support, with the authorization of the board, community-centered health initiatives designed to address critical risk factors, especially those that contribute to chronic disease;

(i) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the Social Security Act and administer medical assistance under ORS chapter 414;

(j) In consultation with the Director of the Department of Consumer and Business Services, periodically review and recommend standards and methodologies to the Legislative Assembly for:

(A) Review of administrative expenses of health insurers;

(B) Approval of rates; and

(C) Enforcement of rating rules adopted by the Department of Consumer and Business Services;

(k) Structure reimbursement rates for providers that serve recipients of medical assistance to reward comprehensive management of diseases, quality outcomes and the efficient use of resources and to promote cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations;

(L) Guide and support community three-share agreements in which an employer, state or local government and an individual all contribute a portion of a premium for a community-centered health initiative or for insurance coverage;

(m) Develop, in consultation with the Department of Consumer and Business Services, one or more products designed to provide more affordable options for the small group market;

(n) Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4); and

(o) Implement a process for collecting the health outcome and quality measure data identified by the Health Plan Quality Metrics Committee and report the data to the Oregon Health Policy Board.

(2) The Oregon Health Authority is authorized to:

(a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate health care reform in Oregon and to provide comparative cost and quality information to consumers, providers and purchasers of health care about Oregon's health care systems and health plan networks in order to provide comparative information to consumers.

(b) Develop uniform contracting standards for the purchase of health care, including the following:

(A) Uniform quality standards and performance measures;

(B) Evidence-based guidelines for major chronic disease management and health care services with unexplained variations in frequency or cost;

(C) Evidence-based effectiveness guidelines for select new technologies and medical equipment;

(D) A statewide drug formulary that may be used by publicly funded health benefit plans; and

(E) Standards that accept and consider tribal-based practices for mental health and substance abuse prevention, counseling and treatment for persons who are Native American or Alaska Native as equivalent to evidence-based practices.

(3) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on or vested in the Oregon

Health Authority by ORS 413.006 to 413.042, 415.012 to 415.430 and 741.340 or by other statutes. [2009 c.595 §10; 2011 c.500 §5; 2011 c.602 §19; 2011 c.720 §126; 2013 c.1 §56; 2013 c.681 §45; 2015 c.389 §7; 2019 c.364 §4; 2019 c.478 §54d]

413.033 Oregon Health Authority director. (1) The Oregon Health Authority is under the supervision and control of a director, who is responsible for performing the duties, functions and powers of the authority.

(2) The Governor shall appoint the Director of the Oregon Health Authority, who holds office at the pleasure of the Governor. The appointment of the director is subject to confirmation by the Senate in the manner provided by ORS 171.562 and 171.565.

(3) In addition to the procurement authority granted by ORS 279A.050 (6)(b) and except as provided in ORS 279A.050 (7), the director has all powers necessary to effectively and expeditiously carry out the duties, functions and powers vested in the authority by ORS 413.032.

(4) The director shall have the power to obtain such other services as the director considers necessary or desirable, including participation in organizations of state insurance supervisory officials and appointment of advisory committees. A member of an advisory committee so appointed may not receive compensation for services as a member, but, subject to any other applicable law regulating travel and other expenses of state officers, shall receive actual and necessary travel and other expenses incurred in performing official duties.

(5) The director may apply for, receive and accept grants, gifts or other payments, including property or services from any governmental or other public or private person, and may make arrangement to use the receipts, including for undertaking special studies and other projects that relate to the costs of health care, access to health care, public health and health care reform. [2009 c.595 §11; 2011 c.720 §126a; 2012 c.38 §16; 2015 c.167 §2]

413.034 Oregon Health Authority officers and employees. Subject to any applicable provisions of ORS chapter 240, the Director of the Oregon Health Authority shall appoint all subordinate officers and employees of the Oregon Health Authority, prescribe their duties and fix their compensation. [2009 c.595 §13]

413.035 [Formerly 413.211; repealed by 1973 c.651 §11]

413.036 Use of abuse and neglect reports for screening subject individuals; rules. (1) As used in this section:

(a) "Care" means treatment, education, training, instruction, placement services, recreational opportunities, support services or case management, or the supervision of such services, for clients of the Oregon Health Authority.

(b) "Subject individual" means a person who is:

(A) Employed or who seeks to be employed by the authority to provide care;

(B) A volunteer or who seeks to be a volunteer to provide care on behalf of the authority; or

(C) Providing care or who seeks to provide care on behalf of the authority.

(2) The Oregon Health Authority may use abuse and neglect reports, as defined in ORS 409.025, for the purpose of providing protective services or screening subject individuals.

(3) The authority shall adopt rules to carry out the provisions of subsection (2) of this section.

(4) The rules adopted in subsection (3) of this section may include:

(a) Notice and opportunity for due process for an employee of the authority who is found to be unfit; and

(b) Notice and opportunity for hearing in accordance with ORS chapter 183 for a subject individual described in subsection (1)(b)(C) of this section.

(5) Reports used by the authority under this section are confidential and may not be disclosed for any purpose other than in accordance with this section or any other provision of law. [2011 c.720 §50a]

Note: 413.036 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.037 Administering oaths; depositions; subpoenas. (1) The Director of the Oregon Health Authority, each deputy director and authorized representatives of the director may administer oaths, take depositions and issue subpoenas to compel the attendance of witnesses and the production of documents or other written information necessary to carry out the provisions of ORS 413.006 to 413.042, 415.012 to 415.430 and 741.340.

(2) If any person fails to comply with a subpoena issued under this section or refuses to testify on matters on which the person lawfully may be interrogated, the director, deputy director or authorized representative may follow the procedure set out in ORS 183.440 to compel obedience. [2009 c.595 §15; 2013 c.1 §57; 2019 c.478 §55]

413.038 Service of notice by regular mail. (1) The Oregon Health Authority may serve a notice described in ORS 183.415 by regular mail or, if requested by the recipient of the notice, by electronic mail. The legal presumption described in ORS 40.135 (1)(q) does not apply to a notice that is served by regular mail under this section.

(2) Except as provided in subsection (3) of this section, a contested case notice served in accordance with subsection (1) of this section that complies with ORS 183.415 but for service by regular or electronic mail becomes a final order against a party and is not subject to ORS 183.470 (2), upon the earlier of the following:

(a) If the party fails to request a hearing, the day after the date prescribed in the notice as the deadline for requesting a hearing.

(b) The date the authority or the Office of Administrative Hearings mails an order dismissing a hearing request because:

(A) The party withdraws the request for hearing; or

(B) Neither the party nor the party's representative appears on the date and at the time set for hearing.

(3) The authority shall prescribe by rule a period of not less than 60 days after a notice becomes a final order under subsection (2) of this section within which a party may request a hearing under this subsection. If a party requests a hearing within the period prescribed under this subsection, the authority shall do one of the following:

(a) If the authority finds that the party did not receive the written notice and did not have actual knowledge of the notice, refer the request for hearing to the Office of Administrative Hearings for a contested case proceeding on the merits of the authority's intended action described in the notice.

(b) Refer the request for hearing to the Office of Administrative Hearings for a contested case proceeding to determine whether the party received the written notice or had actual knowledge of the notice. The authority must show that the party had actual knowledge of the notice or that the authority mailed the notice to the party's correct address or sent an electronic notice to the party's correct electronic mail address.

(4) If a party informs the authority that the party did not receive a notice served by regular or electronic mail in accordance with subsection (1) of this section, the authority shall advise the party of the right to request a hearing under subsection (3) of this section. [2011 c.720 §50]

Note: 413.038 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.039 [1961 c.620 §23; 1963 c.609 §4; 1965 c.556 §23; repealed by 1965 c.556 §28 and 1969 c.203 §13]

413.040 [Amended by 1961 c.620 §11; renumbered 413.019]

413.041 Persons authorized to represent parties in contested cases. Notwithstanding ORS 8.690, 9.160, 9.320 or 203.145 or ORS chapter 180 or other law, in any contested case proceeding before the Oregon Health Authority, a party that is not a natural person may be represented by an attorney or by any officer or authorized agent or employee of the party. [2011 c.720 §44; 2015 c.7 §10]

Note: 413.041 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.042 Rules. In accordance with applicable provisions of ORS chapter 183, the Director of the Oregon Health Authority may adopt rules necessary for the administration of the laws that the Oregon Health Authority is charged with administering. [2009 c.595 §14]

413.045 [1961 c.620 §22; 1963 c.609 §5; repealed by 1965 c.556 §28 and 1969 c.203 §13]

413.046 Right to courteous, fair and dignified treatment; grievances. (1) All applicants for and recipients of medical assistance, as defined in ORS 414.025, shall be treated in a courteous, fair and dignified manner by Oregon Health Authority employees.

(2) Any applicant or recipient who alleges discourteous, unfair or undignified treatment by an authority employee or alleges that an authority employee has provided incorrect or inadequate information regarding medical assistance programs may file a grievance with the authority. The authority shall publicize the grievance system in each office of the authority that is open to the public.

(3) The grievance shall be discussed first with the supervisor of the employee against whom the grievance is filed. If the grievance is not resolved, the applicant or recipient may discuss the grievance with the manager of the office.

(4) The authority shall compile a monthly report that summarizes each grievance filed against an authority employee and the action taken. The report shall identify each grievance by office and indicate the number of grievances filed against each authority employee. The report shall protect the anonymity of authority employees. The report shall be provided to the Medicaid Advisory Committee established under ORS 414.211. [2013 c.688 §1]

Note: 413.046 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.047 [1963 c.609 §2; repealed by 1965 c.556 §28 and 1969 c.203 §13]

413.049 [1961 c.620 §11b; repealed by 1963 c.609 §6]

413.050 [Amended by 1961 c.620 §12; renumbered 413.068]

413.052 [1963 c.609 §3; 1965 c.556 §24; repealed by 1965 c.556 §28; and 1969 c.203 §13]

413.055 [1961 c.620 §25; repealed by 1965 c.556 §28 and 1969 c.203 §13]

413.059 [1961 c.620 §§27,28; repealed by 1965 c.556 §28 and 1969 c.203 §13]

413.060 [Repealed by 1961 c.171 §4]

413.061 [1963 c.609 §9(4); repealed by 1969 c.203 §13]

413.063 [1963 c.609 §9(1),(2),(3); repealed by 1969 c.203 §13]

413.064 [2009 c.595 §16; 2011 c.720 §127; renumbered 741.340 in 2011]

413.065 [1961 c.620 §29; repealed by 1963 c.609 §6]

413.066 [1963 c.609 §8; repealed by 1969 c.203 §13]

413.068 [Formerly 413.050; 1969 c.203 §3; 1971 c.779 §38; repealed by 2005 c.381 §30]

413.070 [Amended by 1961 c.620 §13; 1969 c.203 §4; 1971 c.779 §39; 2003 c.14 §185; repealed by 2005 c.381 §30]

413.071 Authorization to request federal waivers. Notwithstanding any other provision of law, federal laws shall govern the administration of federally granted funds. The Director of the Oregon Health Authority may request a waiver of any federal law in order to fully implement provisions of state law using federally granted funds. [2011 c.720 §36]

Note: 413.071 and 413.072 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.072 Public process required if waiver of federal requirement involves policy change. (1) As used in this section, "policy change" includes any change in the operation of medical assistance programs that affects recipients adversely in any substantial manner, including but not limited to the denial, reduction, modification or delay of benefits. "Policy change" does not include any procedural change that affects internal management but does not adversely and substantially affect the interest of medical assistance recipients.

(2) The Oregon Health Authority may submit applications for waiver of federal statutory or regulatory requirements to the federal government or any agency of the federal government. Prior to the submission of any application for waiver that involves a policy change, and prior to implementation, the authority shall do the following:

(a) Conduct a public process regarding the application for waiver or application for waiver renewals;

(b) Prepare a complete summary of the testimony and written comments received during the public process;

(c) Submit the application for waiver or application for waiver renewals involving a policy change to the legislative review agency, as described in ORS 291.375, and present the summary of testimony and comments described in this section; and

(d) Give notice of the date of the authority's appearance before the Emergency Board, the Joint Interim Committee on Ways and Means or the Joint Committee on Ways and Means in accordance with ORS 183.335, and before the Medicaid Advisory Committee. [2011 c.720 §94; 2012 c.107 §14]

Note: See note under 413.071.

413.075 [2009 c.595 §26; renumbered 741.381 in 2011]

413.080 [Repealed by 1969 c.597 §281]

413.083 Dental director; duties; rules. (1) The Oregon Health Authority shall appoint a dental director who serves at the pleasure of the authority. The authority may establish by rule additional qualifications for the dental director. The dental director:

(a) Must be a dentist licensed to practice under ORS chapter 679;

(b) Must be in good standing with the Oregon Board of Dentistry or with the dental licensing board of another state if the dental director is not licensed by the board; and

(c) Shall oversee programs operated by the authority that increase access to oral health services, preventative oral health activities and other authority initiatives that address oral health disparities in this state.

(2) The dental director shall:

(a) Provide recommendations and guidance to the authority and other state agencies, individuals and community providers on how to prevent oral diseases and measures to take to improve, promote and protect the oral health of the residents of this state, with a focus on reducing oral health disparities among underserved populations;

(b) Monitor, study and appraise the oral health needs and resources of residents of this state;

(c) Foster the development, expansion and evaluation of oral health services for residents of this state;

(d) Provide information concerning oral health to the dental and health communities and the public;

(e) Develop policies to promote oral health in this state; and

(f) Develop programs, policies and preventive measures to positively impact oral health in this state. [2015 c.395 §1; 2017 c.17 §33]

Note: 413.083 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.084 State School Nursing Consultant; duties. The position of State School Nursing Consultant is created in the Oregon Health Authority. The responsibilities of the consultant include, but are not limited to, all of the following:

(1) Coordinating and collaborating with the school nurse specialist within the Department of Education.

(2) Providing school nursing policy and program guidance for the authority, the department and other agencies.

(3) Supporting and leading the integration of coordinated school health teams and providing assistance in sustaining the teams.

(4) Providing technical assistance to school nurses on the delivery of nursing care using evidence-based best practice standards and assisting in the establishment of protocols and standards of care in collaboration with professional associations and state agencies.

(5) Providing leadership in the delivery of nursing services in schools.

(6) Providing clinical consultation and technical support to school nurses and school nursing programs.

(7) Serving as a liaison and expert resource in school nursing and school nursing programs for local, regional, state and national health care providers and policymaking bodies.

(8) Coordinating school nursing program activities with public health, social services, environmental and educational agencies as well as other public and private entities.

(9) Monitoring, interpreting, synthesizing and disseminating information relevant to changes in health care, school nursing practices, laws and regulations and other legal issues that impact schools.

(10) Promoting quality assurance in school nursing programs by initiating and coordinating a quality assurance program that includes needs assessment, data collection and analysis and evidence-based practices.

(11) Representing school nurses in state level partnerships between agencies and between public and private entities, to foster a coordinated school nursing program and other multidisciplinary collaborations. [2015 c.793 §1]

Note: 413.084 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.085 Cross-delegation by directors of Department of Human Services, Department of Consumer and Business Services and Oregon Health Authority. The Director of Human Services, the Director of the Department of Consumer and Business Services and the Director of the Oregon Health Authority may delegate to each other by interagency agreement any duties, functions or powers granted to the Department of Human Services, the Department of Consumer and Business Services or the Oregon Health Authority by law, as the directors deem necessary for the efficient and effective operation of the respective functions of the departments and the authority. [2009 c.595 §20; 2011 c.720 §224; 2013 c.14 §10; 2013 c.688 §96; 2015 c.3 §44]

Note: 413.085 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.090 [Amended by 1955 c.364 §7; 1961 c.620 §14; 1969 c.68 §7; 1971 c.779 §40; repealed by 2005 c.381 §30]

413.100 [Amended by 1971 c.734 §44; 1971 c.779 §41; repealed by 2005 c.381 §30]

FINANCIAL ADMINISTRATION

413.101 Oregon Health Authority Fund. The Oregon Health Authority Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Oregon Health Authority Fund shall be credited to the fund. Moneys in the fund are continuously appropriated to the Oregon Health Authority for carrying out the duties, functions and powers of the authority under ORS 413.032 and 431A.183. [Formerly 413.031; 2019 c.456 §10]

413.105 Deposit of reimbursements received for medical assistance expenditures. All sums of money recovered by or paid to the Oregon Health Authority as reimbursement for funds expended for medical assistance shall be paid into the Oregon Health Authority Fund established by ORS 413.101 and may be used for the provision and administration of medical assistance. However, the United States Government is entitled to a share of any amount received as its interest may appear, which shall be promptly paid to the United States Government. [2011 c.720 §46]

Note: 413.105 to 413.151 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.109 Acceptance and expenditures of funds received from private sources. (1) The Oregon Health Authority may accept funds, money or other valuable things from relatives, corporations or interested persons or organizations for the care and support of needy persons and may expend the same for the care and support of the individual or individuals for whom the moneys were paid.

(2) The authority may accept from individuals, corporations and organizations contributions or gifts in cash or otherwise that shall be disbursed in the same manner as moneys appropriated for medical assistance purposes, unless the donor of a gift stipulates a different manner in which

a gift must be expended. Moneys received under this section shall be deposited with the State Treasurer in an account separate and distinct from the General Fund. Interest earned by the account shall be credited to the account. Moneys in the account are continuously appropriated to the department for the purposes specified in this section. [2011 c.720 §45; 2013 c.688 §66]

Note: See note under 413.105.

413.110 [Amended by 1955 c.381 §1; 1971 c.779 §42; repealed by 2005 c.381 §30]

413.120 [Amended by 1955 c.381 §2; 1961 c.620 §15; 1965 c.43 §1; 1973 c.651 §9; 2005 c.22 §283; repealed by 2005 c.381 §30]

413.121 Oregon Health Authority Special Checking Account. (1) There is established an Oregon Health Authority Special Checking Account in the State Treasury. Upon the written request of the Director of the Oregon Health Authority, the Oregon Department of Administrative Services shall draw payments in favor of the authority to be charged against appropriations and other moneys available to the authority in the same manner as other claims against the state, as provided in ORS chapter 293. All such payments shall be deposited in the special checking account and may be disbursed by check or other means acceptable to the State Treasurer.

(2) The special checking account may be used for the purpose of paying the administrative expenses of programs and services as assigned to the authority by law, including the payment of expenses to be reimbursed by the federal government.

(3) In addition to funds authorized under ORS 293.180, the authority may establish petty cash funds out of the special checking account or any account established in the State Treasury for the authority. The authority may pay expenses using small cash disbursements from a petty cash fund. Periodically, the authority shall request reimbursement for disbursements made from a petty cash fund. Upon receipt of a reimbursement payment from an appropriate account, the authority shall use the payment to reimburse the petty cash fund. [2011 c.720 §37]

Note: See note under 413.105.

413.125 Revolving fund. (1) On written request of the Oregon Health Authority, the Oregon Department of Administrative Services shall draw warrants on amounts appropriated to the authority for operating expenses for use by the authority as a revolving fund. The revolving fund may not exceed the aggregate sum of $100,000 including unreimbursed advances. The revolving fund shall be deposited with the State Treasurer to be held in a special account against which the authority may draw checks.

(2) The revolving fund may be used by the authority:

(a) To pay for or advance travel expenses for employees of the authority and for any consultants or advisers for whom payment of travel expenses is authorized by law;

(b) For purchases required from time to time; or

(c) For receipt or disbursement of federal funds available under federal law.

(3) All claims for reimbursement of amounts paid from the revolving fund must be approved by the authority and by the department. When such claims are approved, the department shall

draw a warrant covering them against the appropriate fund or account in favor of the authority. The authority shall use the moneys to reimburse the revolving fund. [2011 c.720 §40]

Note: See note under 413.105.

413.127 [2013 c.177 §2; repealed by 2015 c.829 §9]

413.129 Aggregation of warrants and payments. The Oregon Department of Administrative Services shall draw warrants in favor of the Oregon Health Authority for the aggregate amounts of the authority's expenses. The authority shall deposit the warrants in the State Treasury in a checking account in reimbursement of those expenses. The authority may draw its checks on the State Treasury in favor of the persons, firms, corporations, associations or counties entitled to payment under rules of the authority so as to include in single combined payments for specified periods all moneys allotted to particular payees from various sources for the period. [2011 c.720 §39]

Note: See note under 413.105.

413.130 [Amended by 1961 c.620 §16; 1969 c.203 §6; repealed by 2005 c.381 §30]

413.135 Combining and eliminating accounts. Notwithstanding any other law, the Oregon Health Authority may, with the approval of the Oregon Department of Administrative Services and the State Treasurer, combine or eliminate any accounts that are established in statute and appropriated to the authority if economy and efficiency in operations can be obtained and the combination or elimination of accounts does not substantially alter the intent of the authorizing statutes. When accounts are combined, the Oregon Health Authority retains the authority granted by the statutes establishing the accounts. [2011 c.720 §38]

Note: See note under 413.105.

413.140 [Amended by 1961 c.620 §17; 1969 c.203 §7; 2003 c.14 §186; repealed by 2005 c.381 §30]

413.150 [Renumbered 413.025]

413.151 Setoff of liquidated and delinquent debts. Liquidated and delinquent debts owed to the Oregon Health Authority may be set off against amounts owed by the authority to the debtors. [2011 c.720 §43]

Note: See note under 413.105.

413.160 [Amended by 1957 c.56 §3; 1971 c.779 §43; repealed by 2005 c.381 §30]

COLLECTION, RETENTION AND DISCLOSURE OF RECORDS

413.161 Collection of data on race, ethnicity, language and disability status. (1) The Oregon Health Authority, in collaboration with the Department of Human Services, shall adopt by rule uniform standards, based on local, statewide and national best practices, for the collection of data on race, ethnicity, preferred spoken and written languages and disability status. The authority and the department shall use the standards, to the greatest extent practicable, in surveys conducted and in all programs in which the authority or the department collects, records or reports such data. The authority and the department shall review and update the standards at least once every two years to ensure that the standards are efficient, uniform and consistent with best practices.

(2) The authority shall appoint an advisory committee in accordance with ORS 183.333 composed of individuals likely to be affected by the standards and advocates for individuals likely to be affected by the standards. [2013 c.264 §1]

Note: 413.161 to 413.195 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.162 Reports to Legislative Assembly on collection of data under ORS 413.161. No later than June 1, 2014, and every two years thereafter, the Oregon Health Authority and the Department of Human Services shall report to the appropriate committees of the Legislative Assembly in the manner provided in ORS 192.245 on the implementation of ORS 413.161. The report must include, but is not limited to:

(1) A description of the uniform standards for data collection and the implementation of the standards across all data systems; and

(2) The challenges to implementing systemwide standards and the plan for addressing the challenges. [2013 c.264 §2]

Note: See note under 413.161.

413.165 [1965 c.556 §26; 1971 c.779 §44; 1973 c.823 §130; 2001 c.900 §99a; repealed by 2005 c.381 §30]

413.170 [Amended by 1961 c.620 §18; 1969 c.203 §8; repealed by 2001 c.900 §261]

413.171 Sharing of data with Department of Human Services; rules. (1) The Oregon Health Authority shall adopt and enforce rules governing the custody, use and preservation of the records, papers, files and communications of the authority in accordance with applicable privacy laws. The use of the records, papers, files and communications is limited to the purposes for which they are furnished and by the provisions of law under which they may be furnished.

(2) The records, papers, files and communications of the authority may be maintained in a single or combined data system accessible to the authority and to the Department of Human Services for the administration of programs and the coordination of functions shared by the authority and the department. [2011 c.720 §48]

Note: See note under 413.161.

413.175 Prohibition on disclosure of information; exceptions. (1) For the protection of applicants for and recipients of public assistance and medical assistance, as defined in ORS 414.025, except as otherwise provided in this section, the Oregon Health Authority may not disclose or use the contents of any public assistance or medical assistance records, files, papers or communications for purposes other than those directly connected with the administration of the public assistance and medical assistance programs or necessary to assist public assistance or medical assistance applicants and recipients in accessing and receiving other governmental or private nonprofit services, and these records, files, papers and communications are considered confidential subject to the rules of the authority. In any judicial or administrative proceeding, except proceedings directly connected with the administration of public assistance, medical assistance or child support enforcement, their contents are considered privileged communications.

(2) Nothing in this section prohibits the disclosure or use of contents of records, files, papers or communications for purposes directly connected with the establishment and enforcement of support obligations pursuant to Title IV-D of the Social Security Act.

(3) Nothing in this section prohibits the disclosure of the address, Social Security number and photograph of any applicant or recipient to a law enforcement officer at the request of the officer. To receive information pursuant to this section, the officer must furnish the agency the name of the applicant or recipient and advise that the applicant or recipient:

(a) Is fleeing to avoid prosecution, custody or confinement after conviction for a felony;

(b) Is violating a condition of probation or parole; or

(c) Has information that is necessary for the officer to conduct the official duties of the officer and the location or apprehension of the applicant or recipient is within such official duties.

(4) Nothing in this section prohibits disclosure of information between the authority and the Department of Human Services for the purpose of administering public assistance and medical assistance programs that the authority and the department are responsible for administering. [2011 c.720 §49; 2013 c.688 §67]

Note: See note under 413.161.

413.180 [Amended by 1961 c.620 §19; 1969 c.203 §9; 1971 c.779 §45; repealed by 2001 c.900 §261]

413.181 Disclosure of insurer information by Department of Consumer and Business Services for purpose of administering Oregon Integrated and Coordinated Care Delivery System. (1) The Department of Consumer and Business Services and the Oregon Health Authority may enter into agreements governing the disclosure of information reported to the department by insurers with certificates of authority to transact insurance in this state and the disclosure of information reported to the Oregon Health Authority by coordinated care organizations.

(2) The authority may use information disclosed under subsection (1) of this section for the purpose of carrying out ORS 413.032, 414.572, 414.591, 414.605, 414.609, 414.638 and 415.012 to 415.430. [2012 c.8 §6; 2015 c.389 §8; 2019 c.478 §56]

Note: See note under 413.161.

413.190 [Renumbered 413.029]

413.195 Disclosure of information about cremated remains. (1) As used in this section, "family member" means any individual related by blood, marriage or adoption to a person whose cremated remains are in the possession of the Oregon Health Authority.

(2) Notwithstanding any other provision of law, the authority shall disclose to the general public the name and the dates of birth and death of a person whose cremated remains are in the possession of the authority for the purpose of:

(a) Giving a family member of the person an opportunity to claim the cremated remains; or

(b) Creating a memorial for those persons whose cremated remains are not claimed.

(3) If an individual contacts the authority to determine whether the authority is in possession of the cremated remains of a family member of the individual and the authority determines that the authority is in possession of the cremated remains, the authority shall disclose to the individual that the authority is in possession of the cremated remains and offer the individual the opportunity to claim the remains. [Formerly 413.850]

Note: See note under 413.161.

413.196 Confidentiality and inadmissibility of information obtained in connection with epidemiologic morbidity and mortality studies; exceptions; nonliability of informants. (1)(a) All information procured by or furnished to the Oregon Health Authority, any federal public health agency or any nonprofit health agency that is exempt from taxation under the laws of this state or procured by any agency, organization or person acting jointly with or at the request of the authority, in connection with special epidemiologic morbidity and mortality studies, is confidential, nondiscoverable and inadmissible in any proceeding and is exempt from disclosure under ORS 192.311 to 192.478. A person communicating information in connection with special epidemiologic morbidity and mortality studies pursuant to this subsection may not be examined about the communication or the information.

(b) Nothing in this subsection affects the confidentiality or admissibility into evidence of data not otherwise confidential or privileged that is obtained from sources other than the authority.

(c) As used in this subsection, "information" includes, but is not limited to, written reports, notes, records, statements and studies.

(2) The furnishing of morbidity and mortality information to the authority or health agency, to its authorized representatives or to any other agency, organization or person cooperating in a special epidemiologic study, does not subject any hospital, sanitarium, rest home, nursing home or other organization or person furnishing such information to an action for damages.

(3) Subsection (1) of this section does not prevent the authority or a health agency from publishing:

(a) Statistical compilations and reports relating to special epidemiologic morbidity and mortality studies, if such compilations and reports do not identify individual cases and sources of information.

(b) General morbidity and mortality studies customarily and continuously conducted by the authority or health agency that do not involve patient identification.

(4) Nothing in this section prevents disposition of records described in subsection (1) of this section pursuant to ORS 192.105. [Formerly 432.060]

413.200 [Amended by 1955 c.444 §4; 1961 c.620 §20; subsection (2) enacted as 1961 c.620 §7; 1969 c.203 §10; 1971 c.455 §1; 1975 c.386 §3; 1985 c.522 §3; 1993 c.249 §4; 1995 c.664 §93; repealed by 2005 c.381 §30]

HEALTH CARE DELIVERY SYSTEM CAPACITY

413.201 Targeted outreach for Health Care for All Oregon Children program; grants to address health care access barriers. (1) The Oregon Health Authority is responsible for statewide outreach and marketing of the Health Care for All Oregon Children program established in ORS 414.231 and administered by the authority with the goal of enrolling in the program all eligible children residing in this state. The authority, in collaboration with the work group described in subsection (3) of this section, shall evaluate and implement the outreach and marketing strategies designed to most effectively encourage the enrollment of children in the program.

(2) To maximize the enrollment and retention of eligible children in the Health Care for All Oregon Children program, the authority shall develop and administer a grant program to provide funding to organizations and community based groups to deliver culturally specific and targeted outreach and direct application assistance to:

(a) Members of racial, ethnic and language minority communities;

(b) Children living in geographic isolation; and

(c) Children and family members with additional barriers to accessing health care, such as cognitive, mental health or sensory disorders, physical disabilities or chemical dependency, and children experiencing homelessness.

(3) The authority shall convene a work group, consisting of individuals with experience in conducting outreach to the individuals described in subsection (2)(a) to (c) of this section, to advise and assist the authority in carrying out its duties under this section. [2009 c.867 §34; 2009 c.828 §57; 2013 c.681 §46; 2017 c.652 §1]

413.210 [Repealed by 1953 c.500 §12]

413.211 [1957 c.705 §2; renumbered 413.035]

413.220 [Repealed by 2005 c.381 §30]

413.223 School-based health centers; certification; best practices; rules. The division of the Oregon Health Authority that is charged with public health functions:

(1) Shall develop and continuously refine a system of care that:

(a) Meets the developmental needs of adolescents;

(b) Promotes evidence-based practices for children; and

(c) Prioritizes public health through activities such as:

(A) Establishing certification and performance standards;

(B) Collecting and analyzing clinical data;

(C) Conducting ongoing assessments and special studies; and

(D) Defining a statewide planning and development process.

(2) Shall adopt by rule the procedures and criteria for the certification, suspension and decertification of school-based health centers. The procedures must allow certified school-based health centers a reasonable period of time to cure any defects in compliance prior to the suspension or decertification of the school-based health center.

(3) Shall convene work groups to recommend best practices for school-based health centers with respect to electronic health records, billing, joint purchasing, business models and patient centered primary care home identification.

(4)(a) May, in addition to the duties described in subsection (1) of this section, enter into a contract with an entity that coordinates the efforts of school-based health centers for the purpose of providing assistance to school-based health centers that receive grant moneys under ORS 413.225.

(b) A contract entered into under this subsection must require the entity to:

(A) Provide technical assistance and community-specific ongoing training to school-based health centers, school districts and education service districts;

(B) Assist school-based health centers in improving business practices, including practices related to billing and efficiencies;

(C) Assist school-based health centers in expanding their relationships with coordinated care organizations, sponsors of medical care for school-age children and other community-based providers of school-based health and mental health services; and

(D) Facilitate the integration of health and education policies and programs at the local level so that school-based health centers operate in an optimal environment. [2013 c.683 §1; 2019 c.536 §2]

Note: 413.223 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

Note: Sections 1 and 5, chapter 601, Oregon Laws 2019, provide:

Sec. 1. (1) The Oregon Health Authority, in consultation with the Department of Education, shall select 10 school districts or education service districts to receive planning grants for district planning and technical assistance. Each district receiving a grant, beginning on or after July 1, 2019, and concluding before July 1, 2021, shall:

(a) Evaluate the need for school-based health services in their respective communities; and

(b) Develop a plan that addresses the need identified in paragraph (a) of this subsection by drafting a proposal for a school-based health center as defined in ORS 413.225 or by designing a pilot program as described in subsection (5)(b) of this section to test an alternative approach to providing school-based health services.

(2) Each grantee shall consult with a nonprofit organization with experience in organizing community projects, or a local organization that coordinates with a statewide nonprofit organization, to facilitate the planning process and to provide technical assistance.

(3) Each grantee shall solicit community participation in the planning process, including the participation of the local public health authority, any federally qualified health centers located in the district, a regional health equity coalition, if any, serving the district and every coordinated care organization with members residing in the district.

(4) The Oregon Health Authority may contract with a statewide nonprofit organization with experience in supporting school-based health centers to create tools and provide support to grantees during the community engagement and planning process.

(5) At the conclusion of the two-year planning process:

(a) The authority shall select at least six school-based health center medical sponsors to each receive operating funds based on a school-based health center funding formula, to open a state-certified school-based health center in respective grantee school districts or education service districts.

(b) Contingent upon available funds, the authority may select up to four school districts or education service districts to each receive operating funds, for a five-year period, to pilot an approach to providing school-based health services as an alternative model to the school-based health center model. The alternative approach pilot programs may be designed to focus services on a specific community need, such as a need for mental health services, school nursing services, dental services, primary care or trauma-informed services, and may:

(A) Involve a partnership with a coordinated care organization, a federally qualified health center, a local public health authority or another major medical sponsor; and

(B) Identify a process for billing insurance, medical assistance or another third-party payer, or identify other funding, for the cost of services.

(6) By the end of the fourth year of the five-year period described in subsection (5)(b) of this section:

(a) Each school district or education service district piloting an alternative approach to providing school-based health services either commits to establish a school-based health center or proposes an alternative model to the authority and the Legislative Assembly.

(b) The authority may use the data collected and the recommendations of the school districts to adopt rules establishing flexible, outcome-based criteria for certification of the alternative approaches developed and implemented by the four grantees.

(7) As used in this section, "regional health equity coalition" means a coalition that:

(a) Is independent of coordinated care organizations and government agencies, community-led, cross-sector and focused on addressing rural and urban health inequities for communities of color, Oregon's federally recognized Indian tribes, immigrants, refugees, migrant and seasonal farm workers, low-income populations, persons with disabilities and persons who are lesbian, gay, bisexual, transgender or questioning, with communities of color as the priority;

(b) May include as member organizations a federally recognized Indian tribe, a culturally specific organization, a social service provider, a health care organization, a public health research organization, a behavioral health organization, a private foundation or a faith-based organization;

(c) Develops governance structures that include members of communities impacted by health inequities;

(d) Has a decision-making body on which more than half of the persons are self-identified persons of color and more than half of the persons experience health inequities;

(e) Prioritizes selection of organizational representatives who are self-identified persons of color or have a role related to health equity;

(f) Operates on a model that honors community wisdom by promoting solutions that build on community strengths and recognizes the impact of structural, institutional and interpersonal racism on the health and well-being of communities of color; and

(g) Focuses on:

(A) Meaningful community engagement;

(B) Coalition building, developing a governance structure for the coalition and creating operating systems for the daily and long term functioning of the coalition led by individuals with demonstrated leadership and expertise in promoting and improving health equity;

(C) Building capacity and leadership among coalition members, staff and decision-making bodies to address health equity and the social determinants of health; and

(D) Developing and advocating for policy, system and environmental changes to improve health equity in this state. [2019 c.601 §1]

Sec. 5. Section 1 of this 2019 Act is repealed on January 2, 2026. [2019 c.601 §5]

413.225 Grants to safety net providers; evaluation of implementation of Health Care for All Oregon Children program; rules. (1) As used in this section:

(a) "Community health center or safety net clinic" means a nonprofit medical clinic or school-based health center that provides primary physical health, vision, dental or mental health services to low-income patients without charge or using a sliding scale based on the income of the patient.

(b) "School-based health center" means a health clinic that:

(A) Is located on the grounds of a school in a school district or on the grounds of a school operated by a federally recognized Indian tribe or tribal organization;

(B) Is organized through collaboration among schools, communities and health providers, including public health authorities;

(C) Is administered by a county, state, federal or private organization that ensures that certification requirements are met and provides project funding through grants, contracts, billing or other sources of funds;

(D) Is operated exclusively for the purpose of providing health services such as:

(i) Primary care;

(ii) Preventive health care;

(iii) Management and monitoring of chronic health conditions;

(iv) Behavioral health care;

(v) Oral health care;

(vi) Health education services; and

(vii) The administration of vaccines recommended by the Centers for Disease Control and Prevention;

(E) Provides health services to children and adolescents by licensed or certified health professionals; and

(F) May provide one or more health services to children and adolescents by:

(i) A student enrolled in a professional medical, nursing or dental program at an accredited university if the health service is within the student's field of study and training; or

(ii) An expanded practice dental hygienist holding a permit issued under ORS 680.200 for oral health care.

(2)(a) The Oregon Health Authority shall award grants to community health centers or safety net clinics, including school-based health centers, to ensure the capacity of each grantee to provide health care services to underserved or vulnerable populations.

(b) The authority shall work with the Centers for Medicare and Medicaid Services and stakeholders to identify additional sources of funding for school-based health center expenditures

for which federal financial participation is available under Title XIX or Title XXI of the Social Security Act.

(3) The authority shall provide outreach for the Health Care for All Oregon Children program, including development and administration of an application assistance program, and including grants to provide funding to organizations and local groups for outreach and enrollment activities for the program, within the limits of funds provided by the Legislative Assembly for this purpose.

(4) The authority shall, using funds allocated by the Legislative Assembly:

(a) Provide funds for the expansion and continuation of school-based health centers that are operating on July 29, 2013, and that become certified under ORS 413.223;

(b) Direct funds to communities with certified school-based health centers and to communities planning for certified school-based health centers; and

(c) Create a pool of funds available to provide financial incentives to:

(A) Increase the number of school-based health centers identified as patient centered primary care homes without requiring school-based health centers to be identified as patient centered primary care homes;

(B) Improve the coordination of the care of patients served by coordinated care organizations and school-based health centers; and

(C) Improve the effectiveness of the delivery of health services through school-based health centers to children who qualify for medical assistance.

(5) The authority shall by rule adopt criteria for awarding grants and providing funds in accordance with this section.

(6) The authority shall analyze and evaluate the implementation of the Health Care for All Oregon Children program. [2009 c.867 §33; 2009 c.828 §56; 2013 c.683 §2; 2019 c.536 §3; 2019 c.601 §2]

413.230 [Amended by 1961 c.620 §31; 1991 c.67 §106; repealed by 2005 c.381 §30]

413.231 Recruitment of primary care providers. The Oregon Health Authority, through the Health Care Workforce Committee created pursuant to ORS 413.017, shall work with interested parties, which may include Travel Oregon, the State Workforce and Talent Development Board, medical schools, physician organizations, hospitals, county and city officials, local chambers of commerce, organizations that promote Oregon or local communities in Oregon, and organizations that recruit health care professionals, to develop a strategic plan for recruiting primary care providers to Oregon. The strategic plan must address:

(1) Best recruitment practices and existing recruitment programs;

(2) Development of materials and information promoting Oregon as a desirable place for primary care providers to live and work;

(3) Development of a pilot program to promote coordinated visiting and recruitment opportunities for primary care providers;

(4) Potential funding opportunities; and

(5) The best entities to implement the strategic plan. [2011 c.361 §1; 2017 c.185 §9; 2017 c.297 §23]

Note: 413.231, 413.246 and 413.248 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.233 [2013 c.177 §1; repealed by 2015 c.829 §9]

413.234 Supplemental payments to emergency services providers. (1) As used in ORS 413.234 and 413.235:

(a) "Emergency medical services" means the services provided by emergency medical services providers to an individual experiencing a medical emergency in order to:

(A) Assess, treat and stabilize the individual's medical condition; or

(B) Prepare and transport the individual by ground to a medical facility.

(b) "Emergency medical services provider" or "provider" means an entity that:

(A) Employs individuals who are licensed by the Oregon Health Authority under ORS chapter 682 to provide emergency medical services; and

(B)(i) Is owned or operated by a local government, a state agency or a federally recognized Indian tribe; or

(ii) Contracts with a local government pursuant to a plan described in ORS 682.062.

(c) "Federal financial participation" means the portion of medical assistance expenditures for emergency medical services that are paid or reimbursed by the Centers for Medicare and Medicaid Services in accordance with the state plan for medical assistance.

(d) "Local government" has the meaning given that term in ORS 174.116.

(2) Upon request, an emergency medical services provider that has entered into a provider agreement with the authority is eligible to receive Medicaid supplemental reimbursement from the authority for the cost of providing emergency medical services to a medical assistance recipient. The Medicaid supplemental reimbursement shall be added to the payment for the emergency medical services established by the authority in accordance with ORS 414.065.

(3)(a) Except as provided in paragraph (b) of this subsection, the Medicaid supplemental reimbursement paid to an emergency medical services provider shall be equal to the amount of federal financial participation received by the authority for the provider's cost for the emergency medical services.

(b) The Medicaid supplemental reimbursement paid to a provider under this section may not exceed the provider's actual costs for the emergency medical services, determined in accordance with standards established by the authority, less the amount of reimbursement that the provider is eligible to receive from all sources, including the payment amount for emergency medical services established by the authority in accordance with ORS 414.065.

(4) An emergency medical services provider shall make readily available to the authority documentation, data and certifications, as prescribed by the authority, necessary to establish that the emergency medical services expenditures qualify for federal financial participation and to calculate the amount of Medicaid supplemental reimbursement that is due.

(5)(a) Except as provided in paragraph (b) of this subsection, the authority shall modify the method for calculating or paying the Medicaid supplemental reimbursement if modification is necessary to ensure that emergency medical services expenditures qualify for federal financial participation.

(b) This section does not authorize the payment of Medicaid supplemental reimbursement to an emergency medical services provider if the provider has not entered into a provider agreement, with the authority, to serve medical assistance recipients.

(c) If the Centers for Medicare and Medicaid Services approves the implementation of this section and later revokes its approval or expresses its intent to revoke or refuse to renew its approval, the authority shall report the fact at the next convening of the interim or regular session committees of the Legislative Assembly related to health care.

(6) General Fund moneys may not be used to implement this section. As a condition of receiving Medicaid supplemental reimbursement, an emergency medical services provider must enter into and comply with an agreement with the authority to reimburse the authority for the costs of administering this section.

(7) This section applies only to emergency medical services providers that are reimbursed by the authority on a fee-for-service basis. [2016 c.34 §2]

413.235 Emergency services intergovernmental transfer program. (1) The Oregon Health Authority shall develop and implement an intergovernmental transfer program to provide for the transfer of funds from an emergency medical services provider to the authority to pay the costs of providing emergency medical services to members of a coordinated care organization. The authority shall pay any federal financial participation received by the authority as a result of the transfer of funds to the coordinated care organization. The coordinated care organization shall increase, by the same amount, the amount of reimbursement paid to the emergency medical services provider for the costs of the emergency medical services.

(2) The increased reimbursement paid under subsection (1) of this section shall be at least actuarially equivalent to the Medicaid supplemental reimbursement for the emergency medical services paid under ORS 413.234.

(3) General Fund moneys may not be used to implement this section. As a condition of participation in the intergovernmental transfer program described in subsection (1) of this section, an emergency medical services provider must agree to pay a fee to reimburse the authority for the costs of administering the program. The fee may not exceed 20 percent of the cost of the emergency medical services provided. The authority shall allow up to 120 percent of the fee to be counted as an operating cost for providers.

(4) An emergency medical services provider shall make readily available to the authority documentation, data and certifications, as prescribed by the authority, necessary to establish that the emergency medical services expenditures qualify for federal financial participation and to calculate the amount due to a coordinated care organization for the expenditures.

(5) If the authority determines that any expenditure made by an emergency medical services provider does not qualify for federal financial participation, the authority shall return the funds associated with the expenditure to the provider or refuse to accept the transfer of funds associated with the expenditure.

(6) Participation by any coordinated care organization or emergency medical services provider in the program must be voluntary.

(7) The authority shall consult with emergency medical services providers in the development, implementation and operation of the intergovernmental transfer program. [2016 c.34 §3]

413.240 [1961 c.620 §30; 1969 c.203 §11; 2003 c.14 §187; repealed by 2005 c.381 §30]

413.246 Information provided to retired physicians and health care providers. The Oregon Health Authority, in consultation with the appropriate professional and trade associations and licensing boards, shall inform retired physicians and health care providers regarding ORS 30.302 and 30.792. [Formerly 409.740]

Note: See note under 413.231.

413.248 Physician Visa Waiver Program; rules; fees. (1) The Physician Visa Waiver Program is established in the Oregon Health Authority. The purpose of the program is to make recommendations to the United States Department of State for a waiver of the foreign country residency requirement on behalf of foreign physicians holding visas who seek employment in federally designated shortage areas.

(2) A foreign physician who has completed a residency in the United States may apply to the authority for a recommendation for a waiver of the foreign country residency requirement in order to obtain employment in a federally designated shortage area in the state. Applications shall be on the forms of and contain the information requested by the authority. Each application shall be accompanied by the application fee.

(3) The authority reserves the right to recommend or decline to recommend any request for a waiver.

(4) The authority shall adopt rules necessary to implement and administer the program, including but not limited to adopting an application fee not to exceed the cost of administering the program. [Formerly 409.745]

Note: See note under 413.231.

HEALTH CARE PRACTICES

(Health Improvement)

413.250 Statewide Health Improvement Program. (1) There is created in the Oregon Health Authority the Statewide Health Improvement Program to support evidence-based community efforts to prevent chronic disease and reduce the utilization of expensive and invasive acute treatments. The program is composed of activities described in subsection (2) of this section.

(2)(a) The authority may, subject to funding, award one or more grants to support community-based primary and secondary prevention activities focused on chronic diseases, and in line with the goals of the Statewide Health Improvement Program.

(b) To receive a grant under this subsection, an applicant must submit a proposal that:

(A) Includes outside funding of at least 10 percent of the total funding required;

(B) Is developed with community input, including the input of communities most affected by health disparities;

(C) Involves a range of community partners, including a range of multicultural community providers;

(D) Is evidence-based;

(E) Reduces health disparities among populations; and

(F) Contains performance criteria and measurable outcomes to demonstrate, including for communities most affected by health disparities as well as for individuals who are participating in the community-based primary and secondary activity proposal, improvements in population health status and health education and a reduction of chronic disease risk factors. [2009 c.595 §1166]

413.255 Cooperative research and demonstration projects for health and health care purposes. In addition to its other powers, the Oregon Health Authority may:

(1) Enter into agreements with, join with or accept grants from the federal government for cooperative research and demonstration projects for health and health care purposes, including, but not limited to, any project that:

(a) Improves the lifelong health of Oregonians.

(b) Aids in effecting coordination of planning between private and public health and health care agencies of the state.

(c) Improves the administration and effectiveness of programs carried on or assisted by the authority.

(2) With the cooperation and the financial assistance of the federal government, train personnel employed or preparing for employment by the authority. The training may be carried out in any manner, including but not limited to:

(a) Directly by the authority.

(b) Indirectly through grants to public or other nonprofit institutions of learning or through grants of fellowships.

(c) Any other manner for which federal aid in support of the training is available.

(3) Subject to the allotment system provided for in ORS 291.234 to 291.260, expend the sums required to be expended for the programs and projects described in subsections (1) and (2) of this section. [2011 c.720 §47]

Note: 413.255 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.257 Experimental, prototype health care of tomorrow. (1) The Legislative Assembly declares that it is in the best interest of the people of Oregon for the competing health care systems in this state to come together and find a way to envision the future of health care delivery in this state. The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, the collaborative activities described in subsection (2) of this section, that might otherwise be constrained by such laws.

(2) The Director of the Oregon Health Authority shall provide a forum for individuals representing all of the vertically integrated, nonprofit health care systems in this state to participate in meaningful and open discussions and engage in a good faith collaboration to create the experimental, prototype health care of tomorrow.

(3) The collaboration must be guided by the following principles:

(a) Health care must be readily accessible throughout every community in this state;

(b) High quality health care must be provided at a cost much lower than the cost of health care today;

(c) The experimental, prototype health care of tomorrow must incorporate innovations that are gathered from the best minds around the world and can be rapidly implemented throughout the delivery system;

(d) The experimental, prototype health care of tomorrow must continuously implement sufficient improvements in health care to completely offset any increases in cost over extended periods of time; and

(e) The nonprofit health care systems participating in the experimental, prototype health care of tomorrow may not be competitors, but must work together in an integrated fashion to maximize their shared social missions.

(4) The director or the director's designee shall engage in state supervision of the collaboration to ensure that the discussions and activities of the participants in the collaboration are limited to the activities described in this section. [2019 c.194 §1]

Note: 413.257 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

(Patient Centered Care)

413.259 Patient centered primary care home program and behavioral health home program. (1) There is established in the Oregon Health Authority the patient centered primary care home program and the behavioral health home program. Through these programs, the authority shall:

(a) Define core attributes of a patient centered primary care home and a behavioral health home to promote a reasonable level of consistency of services provided by patient centered primary care homes and behavioral health homes in this state. In defining core attributes related to ensuring that care is coordinated, the authority shall focus on determining whether these patient centered primary care homes and behavioral health homes offer comprehensive primary and preventive care, integrated health care and disease management services;

(b) Establish a simple and uniform process to identify patient centered primary care homes and behavioral health homes that meet the core attributes defined by the authority under paragraph (a) of this subsection;

(c) Develop uniform quality measures that build from nationally accepted measures and allow for standard measurement of patient centered primary care home and behavioral health home performance;

(d) Develop uniform quality measures for acute care hospital and ambulatory services that align with the patient centered primary care home and behavioral health home quality measures developed under paragraph (c) of this subsection; and

(e) Develop policies that encourage the retention of, and the growth in the numbers of, primary care providers.

(2)(a) The Director of the Oregon Health Authority shall appoint an advisory committee to advise the authority in carrying out subsection (1) of this section.

(b) The director shall appoint to the advisory committee 15 individuals who represent a diverse constituency and are knowledgeable about patient centered primary care home delivery systems, behavioral health home delivery systems, integrated health care or health care quality.

(c) Members of the advisory committee are not entitled to compensation, but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall be paid out of funds appropriated to the authority for the purposes of the advisory committee.

(d) The advisory committee shall use public input to guide policy development.

(3) The authority will also establish, as part of the patient centered primary care home program, learning collaboratives in which state agencies, private health insurance carriers, third party administrators, patient centered primary care homes and behavioral health homes can:

(a) Share information about quality improvement;

(b) Share best practices that increase access to culturally competent and linguistically appropriate care;

(c) Share best practices that increase the adoption and use of the latest techniques in effective and cost-effective patient centered care;

(d) Coordinate efforts to develop and test methods to align financial incentives to support patient centered primary care homes and behavioral health homes;

(e) Share best practices for maximizing the utilization of patient centered primary care homes and behavioral health homes by individuals enrolled in medical assistance programs, including culturally specific and targeted outreach and direct assistance with applications to adults and children of racial, ethnic and language minority communities and other underserved populations;

(f) Coordinate efforts to conduct research on patient centered primary care homes and behavioral health homes and evaluate strategies to implement patient centered primary care homes and behavioral health homes that include integrated health care to improve health status and quality and reduce overall health care costs; and

(g) Share best practices for maximizing integration to ensure that patients have access to comprehensive primary and preventive care, integrated health care and disease management services.

(4) The Legislative Assembly declares that collaboration among public payers, private health carriers, third party purchasers and providers to identify appropriate reimbursement methods to align incentives in support of patient centered primary care homes and behavioral health homes is in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws, the collaborative and associated payment reforms designed and implemented under subsection (3) of this section that might otherwise be constrained by such laws. The Legislative Assembly does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state or federal antitrust laws including, but not limited to, agreements among competing health care providers or health carriers as to the prices of specific levels of reimbursement for health care services.

(5) The authority may contract with a public or private entity to facilitate the work of the learning collaborative described in subsection (3) of this section and may apply for, receive and accept grants, gifts, payments and other funds and advances, appropriations, properties and services from the United States, the State of Oregon or any governmental body or agency or from any other public or private corporation or person for the purpose of establishing and maintaining the collaborative. [Formerly 442.210; 2019 c.536 §1]

413.260 Patient centered primary care and behavioral health home delivery models. (1) The Oregon Health Authority, in collaboration with health insurers and purchasers of health plans including the Public Employees' Benefit Board, the Oregon Educators Benefit Board and other members of the patient centered primary care home learning collaborative and the patient centered primary care home program advisory committee, shall:

(a) Develop, test and evaluate strategies that reward enrollees in publicly funded health plans for:

(A) Receiving care through patient centered primary care homes and behavioral health homes that meet the core attributes established in ORS 413.259;

(B) Seeking preventative and wellness services;

(C) Practicing healthy behaviors; and

(D) Effectively managing chronic diseases.

(b) Develop, test and evaluate community-based strategies that utilize community health workers to enhance the culturally competent and linguistically appropriate health services provided by patient centered primary care homes and behavioral health homes in underserved communities.

(2) The authority shall focus on patients with chronic health conditions in developing strategies under this section.

(3) The authority, in collaboration with the Public Employees' Benefit Board and the Oregon Educators Benefit Board, shall establish uniform standards for contracts with health benefit plans providing coverage to public employees to promote the provision of patient centered primary care homes, especially for enrollees with chronic medical conditions, and behavioral health homes that are consistent with the uniform quality measures established under ORS 413.259 (1)(c).

(4) The standards established under subsection (3) of this section may direct health benefit plans to provide incentives to primary care providers who serve vulnerable populations to partner with health-focused community-based organizations to provide culturally specific health promotion and disease management services. [2009 c.595 §1165; 2015 c.318 §21; 2015 c.798 §6; 2019 c.536 §4]

(Palliative Care)

413.270 Advisory council; membership; duties. (1) The Palliative Care and Quality of Life Interdisciplinary Advisory Council is established in the Oregon Health Authority consisting of nine members appointed by the Director of the Oregon Health Authority.

(2) The council shall consult with and advise the director on:

(a) Matters related to the establishment, maintenance, operation and evaluation of palliative care initiatives in this state; and

(b) The implementation of ORS 413.273.

(3) The members of the council must include:

(a) Individuals with collective expertise in interdisciplinary palliative care provided in a variety of settings and to children, youths, adults and the elderly;

(b) Individuals with expertise in nursing, social work and pharmacy;

(c) Members of the clergy or individuals who have professional spiritual expertise; and

(d) At least two board-certified physicians or nurses with expertise in palliative care.

(4) The term of office of each member is three years but a member serves at the pleasure of the director. Before the expiration of the term of a member, the director shall appoint a successor whose term begins on January 1, next following. A member is eligible for reappointment. If there is a vacancy for any cause, the director shall make an appointment to become immediately effective for the unexpired term.

(5) The council shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the council determines.

(6) A majority of the members of the council constitutes a quorum for the transaction of business.

(7) The council shall meet at least twice every year at a place, day and hour determined by the council. The council may also meet at other times and places specified by the call of the chairperson or of a majority of the members of the council.

(8) A member of the council is not entitled to compensation but in the discretion of the director may be reimbursed from funds available to the authority for actual and necessary travel and other expenses incurred by the member in the performance of the member's official duties in the manner and amount provided in ORS 292.495.

(9) The authority shall provide staff support to the council. [2015 c.789 §1]

Note: 413.270 to 413.273 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.271 Palliative care information and resources. (1) The Oregon Health Authority shall publish on its website information and resources, including links to external resources, about palliative care. This may include, but is not limited to:

(a) Continuing educational opportunities for health care providers;

(b) Information about palliative care delivery in the home and in primary, secondary and tertiary care facilities;

(c) Best practices for and cultural competency in the delivery of palliative care;

(d) Consumer education materials; and

(e) Referral information for culturally competent palliative care.

(2) The authority shall consult with the Palliative Care and Quality of Life Interdisciplinary Advisory Council in carrying out this section. [2015 c.789 §4]

Note: See note under 413.270.

413.273 Palliative care for patients and residents of hospitals, long term care facilities and residential care facilities. (1) As used in this section and ORS 413.270 and 413.271:

(a) "Appropriate" means consistent with applicable legal, health and professional standards, a patient's clinical and other circumstances, and the patient's known wishes and beliefs.

(b) "Health facility" includes:

(A) Hospitals and long term care facilities licensed under ORS 441.025; and

(B) Residential facilities licensed under ORS 443.415.

(c) "Medical care" means professional services for a patient that are provided, requested or supervised by a physician, nurse practitioner or physician assistant.

(d)(A) “Palliative care” means patient-centered and family-centered medical care that optimizes a patient’s quality of life by anticipating, preventing and treating the suffering caused by serious illness and involves addressing the patient’s physical, social and spiritual needs and facilitating the patient’s autonomy, access to information and choice.

(B) “Palliative care” includes, but is not limited to:

(i) Discussing a patient’s goals for treatment;

(ii) Discussing the treatment options that are appropriate for the patient; and

(iii) Comprehensive pain and symptom management.

(e) “Serious illness” means any illness, physical injury or condition that substantially impairs a patient’s quality of life for more than a short period of time.

(2) A health facility shall:

(a) Establish a system for identifying patients or residents who could benefit from palliative care;

(b) Provide information to patients, residents and their families about palliative care; and

(c) Coordinate with a patient’s or resident’s primary care provider, if practicable, to facilitate the access of patients and residents with serious illnesses to appropriate palliative care. [2015 c.789 §5]

Note: See note under 413.270.

HEALTH INFORMATION TECHNOLOGY

413.300 Definitions for ORS 413.300 to 413.308, 413.310 and ORS chapter 414. As used in ORS 413.300 to 413.308, 413.310 and ORS chapter 414:

(1) “Electronic health record” means an electronic record of an individual’s health-related information that conforms to nationally recognized interoperability standards and that can be created, managed and consulted by authorized health care providers and staff.

(2) “Health care provider” or “provider” means a person who is licensed, certified or otherwise authorized by law in this state to administer health care in the ordinary course of business or in the practice of a health care profession.

(3) “Health informatics” means the interdisciplinary study of the design, development, adoption and application of information technology based innovations in health care services delivery, management and planning.

(4) “Health information technology” means an information processing application using computer hardware and software for the storage, retrieval, sharing and use of health care information, data and knowledge for communication, decision-making, quality, safety and efficiency of a clinical practice. “Health information technology” includes, but is not limited to:

(a) An electronic health record.

(b) An electronic order from a health care provider for diagnosis, treatment or prescription drugs.

(c) An electronic clinical decision support system that links health observations with health knowledge to assist health care providers in making choices for improved health care, for example by providing electronic alerts or reminders.

(d) Tools for the collection, analysis and reporting of information or data on adverse events, the quality and efficiency of care, patient satisfaction and other health care related performance measures.

(5) “Interoperability” means the capacity of different health information technology systems and software applications to communicate and exchange data and to make use of the data that has been exchanged. [2009 c.595 §1167; 2015 c.243 §3]

413.301 Health Information Technology Oversight Council. (1) There is established a Health Information Technology Oversight Council within the Oregon Health Authority. The Oregon Health Policy Board shall:

(a) Determine the terms of members on the council and the organization of the council.

(b) Appoint members to the council who, collectively, have expertise, knowledge or direct experience in health care delivery, health information technology, health informatics and health care quality improvement.

(c) Ensure that there is broad representation on the council of individuals and organizations that will be impacted by the Oregon Health Information Technology program.

(2) To aid and advise the council in the performance of its functions, the council may establish such advisory and technical committees as the council considers necessary. The committees may be continuing or temporary. The council shall determine the representation, membership, terms and organization of the committees and shall appoint persons to serve on the committees.

(3) Members of the council are not entitled to compensation, but in the discretion of the board may be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by the members of the council in the performance of their official duties in the manner and amount provided in ORS 292.495. [2009 c.595 §1168; 2015 c.243 §4]

413.302 [2009 c.595 §1170; repealed by 2015 c.243 §9]

413.303 Council chairperson; quorum; meetings. (1) The Health Information Technology Oversight Council shall select one of the council’s members as chairperson, for such term and with such duties and powers necessary for the performance of the functions of the chairperson as the Oregon Health Policy Board determines.

(2) A majority of the members of the council constitutes a quorum for the transaction of business.

(3) The council shall meet at least quarterly at a place, day and hour determined by the council. The council may also meet at other times and places specified by the call of the chairperson or of a majority of the members of the council. [2009 c.595 §1172; 2015 c.243 §5]

413.306 [2009 c.595 §1173; repealed by 2015 c.243 §9]

413.308 Duties of council. The duties of the Health Information Technology Oversight Council are to:

(1) Identify and make specific recommendations related to health information technology to the Oregon Health Policy Board to achieve the goals of the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.570.

(2) Regularly review and report to the board on the Oregon Health Authority’s health information technology efforts, including the Oregon Health Information Technology program, toward achieving the goals of the Oregon Integrated and Coordinated Health Care Delivery System.

(3) Regularly review and report to the board on the efforts of local, regional and statewide organizations to participate in health information technology systems.

(4) Regularly review and report to the board on this state's progress in the adoption and use of health information technology by health care providers, health systems, patients and other users.

(5) Advise the board or the Oregon Congressional Delegation on changes to federal laws affecting health information technology that will promote this state's efforts in utilizing health information technology. [2009 c.595 §1171; 2015 c.243 §6]

413.310 Oregon Health Information Technology program; rules; fees. (1) The Oregon Health Authority shall establish and maintain the Oregon Health Information Technology program to:

(a) Support the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.570;

(b) Facilitate the exchange and sharing of electronic health-related information;

(c) Support improved health outcomes in this state;

(d) Promote accountability and transparency; and

(e) Support new payment models for coordinated care organizations and health systems.

(2) The authority may engage in activities necessary to become accredited or certified as a provider of health information technology and take actions associated with providing health information technology.

(3) Subject to ORS 279A.050 (7), the authority may enter into agreements with other entities that provide health information technology to carry out the objectives of the Oregon Health Information Technology program.

(4) The authority may establish and enforce standards for connecting to and using the Oregon Health Information Technology program, including standards for interoperability, privacy and security.

(5) The authority may conduct or participate in activities to enable and promote the secure transmission of electronic health information between users of different health information technology systems, including activities in other states. The activities may include, but are not limited to, participating in organizations or associations that manage and enforce agreements to abide by a common set of standards, policies and practices applicable to health information technology systems.

(6) The authority may, by rule, impose fees on entities or individuals that use the program's services in order to pay the cost of administering the Oregon Health Information Technology program.

(7) The authority may initiate one or more partnerships or participate in new or existing collaboratives to establish and carry out the Oregon Health Information Technology program's objectives. The authority's participation may include, but is not limited to:

(a) Participating as a voting member in the governing body of a partnership or collaborative that provides health information technology services;

(b) Paying dues or providing funding to partnerships or collaboratives;

(c) Entering into agreements, subject to ORS 279A.050 (7), with partnerships or collaboratives with respect to participation and funding in order to establish the role of the authority and protect the interests of this state when the partnerships or collaboratives provide health information technology services; or

(d) Transferring the implementation or management of one or more services offered by the Oregon Health Information Technology program to a partnership or collaborative.

(8) At least once each calendar year the authority shall report to the Legislative Assembly, in the manner provided in ORS 192.245, on the status of the Oregon Health Information Technology program. [2015 c.243 §1]

Note: 413.310 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

HEALTH PROFESSIONALS

413.430 Functions of Director of Oregon Health Authority regarding health professionals. The Director of the Oregon Health Authority shall require each health licensing board in the Oregon Health Authority to maintain a register of the names and current addresses of all persons holding valid licenses, certificates of registration or other evidence of authority required to practice the occupation or profession, or operate the facility within the jurisdiction of such board and periodically, as the director may require, to file a copy of the register at the office of the authority. Any board that is authorized or required to distribute a register described in this section may collect a fee to cover the costs of publication, such fee to be handled as other receipts of the board are handled. [Formerly 409.320]

Note: 413.430 to 413.450 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.435 Administrative requirements for students in clinical training. (1) The Oregon Health Authority, in collaboration with the State Workforce and Talent Development Board, shall convene a work group to develop standards for administrative requirements for student placement in clinical training settings in Oregon. The work group may include representatives of:

(a) State education agencies;

(b) A public educational institution offering health care professional training;

(c) Independent or proprietary educational institutions offering health care professional training;

(d) An employer of health care professionals; and

(e) The Health Care Workforce Committee established under ORS 413.017.

(2)(a) The work group shall develop standards for:

(A) Drug screening;

(B) Immunizations;

(C) Criminal records checks;

(D) Health Insurance Portability and Accountability Act orientation; and

(E) Other standards as the work group deems necessary.

(b) The standards must apply to students of nursing and allied health professions. The standards may apply to students of other health professions.

(c) The standards must pertain to clinical training in settings including but not limited to hospitals and ambulatory surgical centers, as those terms are defined in ORS 442.015.

(3) The work group shall make recommendations on the standards developed under this section and the initial and ongoing implementation of the standards to the Oregon Health Policy Board established in ORS 413.006.

(4) The authority may establish by rule standards for student placement in clinical training settings that incorporate the standards developed under this section and approved by the Oregon Health Policy Board. [2011 c.136 §1; 2017 c.185 §10; 2017 c.297 §24]

Note: See note under 413.430.

413.450 Continuing education in cultural competency. (1) The Oregon Health Authority shall approve continuing education opportunities relating to cultural competency.

(2) The authority shall develop a list of continuing education opportunities relating to cultural competency and make the list available to each board, as defined in ORS 676.850.

(3) The continuing education opportunities may include, but need not be limited to:

(a) Courses delivered either in person or electronically;

(b) Experiential learning such as cultural or linguistic immersion;

(c) Service learning; or

(d) Specially designed cultural experiences.

(4) The continuing education opportunities must teach attitudes, knowledge and skills that enable a health care professional to care effectively for patients from diverse cultures, groups and communities, including but not limited to:

(a) Applying linguistic skills to communicate effectively with patients from diverse cultures, groups and communities;

(b) Using cultural information to establish therapeutic relationships; and

(c) Eliciting, understanding and applying cultural and ethnic data in the process of clinical care.

(5) The authority may accept gifts, grants or contributions from any public or private source for the purpose of carrying out this section. Moneys received by the authority under this subsection shall be deposited into the Oregon Health Authority Fund established by ORS 413.101.

(6) The authority may contract with or award grant funding to a public or private entity to develop the list of or offer approved continuing education opportunities relating to cultural competency. The authority is not subject to the requirements of ORS chapters 279A, 279B and 279C with respect to contracts entered into under this subsection. [2013 c.240 §2]

Note: See note under 413.430.

WOMEN, INFANTS AND CHILDREN PROGRAM

413.500 Women, Infants and Children Program; rules; civil penalties. (1) The Women, Infants and Children Program is established in the Oregon Health Authority. The purpose of the program is to serve as an adjunct to health care by providing nutritious food, nutrition education and counseling, health screening and referral services to pregnant and breast-feeding women and to infants and children in certain high-risk categories.

(2) The authority shall adopt:

(a) Standards and procedures to guide administration of the program by the state in conformity with federal requirements and to define the rights, responsibilities and legal procedures of program vendors; and

(b) Rules necessary to implement and carry out the provisions of this section.

(3)(a) In addition to any other penalty provided by law, the authority may assess a civil penalty against any person for violation of any rule of the authority relating to the Women, Infants and Children Program. The authority shall adopt by rule criteria for the amount of civil penalties to be assessed under this section.

(b) All penalties recovered under this section shall be deposited into the Oregon Health Authority Fund and credited to an account designated by the authority. Moneys deposited are appropriated continuously to the authority and shall be used only for the administration and enforcement of this section. [Formerly 409.600]

Note: 413.500 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

GAMBLING ADDICTION PROGRAMS

413.520 Gambling addiction programs in Oregon Health Authority; advisory committee. (1) The Oregon Health Authority, in collaboration with county representatives, shall develop a plan for the administration of the statewide gambling addiction programs and delivery of program services.

(2) The authority may appoint an advisory committee or designate an existing advisory committee to make recommendations to the authority concerning:

(a) Performance standards and evaluation methodology;

(b) Fiscal reporting and accountability;

(c) Delivery of services; and

(d) A distribution plan for use of available funds.

(3) The distribution plan for the moneys available in the Problem Gambling Treatment Fund shall be based on performance standards.

(4) The authority may enter into an intergovernmental agreement or other contract, subject to ORS chapters 279A, 279B and 279C, for the delivery of services related to programs for the prevention and treatment of gambling addiction and other emotional and behavioral problems related to gambling.

(5) Before entering into an agreement or contract under subsection (4) of this section, the authority must consider the experience, performance and program capacity of those organizations currently providing services. [Formerly 409.430; 2013 c.1 §59; 2015 c.167 §3]

Note: 413.520 and 413.522 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.522 Problem Gambling Treatment Fund. (1) There is established in the State Treasury, separate and distinct from the General Fund, the Problem Gambling Treatment Fund. All moneys in the Problem Gambling Treatment Fund are continuously appropriated to the

Oregon Health Authority to be expended for programs for the prevention and treatment of gambling addiction and other emotional and behavioral problems related to gambling and for the administration of the programs.

(2) The Problem Gambling Treatment Fund shall consist of:

(a) The net proceeds from the Oregon State Lottery allocated to the fund under ORS 461.549;

(b) Moneys appropriated to the fund by the Legislative Assembly; and

(c) Interest earnings on moneys in the fund. [Formerly 409.435]

Note: See note under 413.520.

HEALTH CARE INTERPRETERS

413.550 Definitions for ORS 413.550 to 413.558. As used in ORS 413.550 to 413.558:

(1) "Certified health care interpreter" means an individual who has been approved and certified by the Oregon Health Authority.

(2) "Health care" means medical, surgical or hospital care or any other remedial care recognized by state law, including physical and behavioral health care.

(3) "Health care interpreter" means an individual who is readily able to:

(a) Communicate with a person with limited English proficiency;

(b) Accurately interpret the oral statements of a person with limited English proficiency, or the statements of a person who communicates in sign language, into English;

(c) Sight translate documents from a person with limited English proficiency;

(d) Interpret the oral statements of other persons into the language of the person with limited English proficiency or into sign language; and

(e) Sight translate documents in English into the language of the person with limited English proficiency.

(4) "Person with limited English proficiency" means a person who, by reason of place of birth or culture, speaks a language other than English and does not speak English with adequate ability to communicate effectively with a health care provider.

(5) "Qualified health care interpreter" means an individual who has received a valid letter of qualification from the authority.

(6) "Sight translate" means to translate a written document into spoken or sign language. [Formerly 409.615; 2015 c.318 §1]

Note: 413.550 to 413.560 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.552 Legislative findings and policy on health care interpreters. (1) The Legislative Assembly finds that persons with limited English proficiency, or who communicate in sign language, are often unable to interact effectively with health care providers. Because of language differences, persons with limited English proficiency, or who communicate in sign language, are often excluded from health care services, experience delays or denials of health care services or receive health care services based on inaccurate or incomplete information.

(2) The Legislative Assembly further finds that the lack of competent health care interpreters among health care providers impedes the free flow of communication between the health care

provider and patient, preventing clear and accurate communication and the development of empathy, confidence and mutual trust that is essential for an effective relationship between health care provider and patient.

(3) It is the policy of the Legislative Assembly to require the use of certified health care interpreters or qualified health care interpreters whenever possible to ensure the accurate and adequate provision of health care to persons with limited English proficiency and to persons who communicate in sign language.

(4) It is the policy of the Legislative Assembly that health care for persons with limited English proficiency be provided according to the guidelines established under the policy statement issued August 30, 2000, by the U.S. Department of Health and Human Services, Office for Civil Rights, entitled, "Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency," and the 1978 Patient's Bill of Rights. [Formerly 409.617; 2015 c.318 §2]

Note: See note under 413.550.

413.554 Oregon Council on Health Care Interpreters. (1) The Oregon Council on Health Care Interpreters is created in the Oregon Health Authority. The council shall consist of no more than 15 members, appointed by the Director of the Oregon Health Authority, representing:

(a) Persons with expertise and experience in the administration of or policymaking for programs or services related to interpreters;

(b) Employers or contractors of health care interpreters;

(c) Health care interpreter training programs;

(d) Language access service providers; and

(e) Practicing certified and qualified health care interpreters.

(2) The membership of the council shall be appointed so as to be representative of the racial, ethnic, cultural, social and economic diversity of the people of this state.

(3) The term of a member shall be three years. A member may be reappointed.

(4) If there is a vacancy for any cause, the director shall make an appointment to become immediately effective for the unexpired term. The director may appoint a replacement for any member of the council who misses more than two consecutive meetings of the council. The newly appointed member shall represent the same group as the vacating member.

(5) The council shall select one member as chairperson and one member as vice chairperson, for such terms and with duties and powers as the council determines necessary for the performance of the functions of such offices.

(6) The council may establish such advisory and technical committees as it considers necessary to aid and advise the council in the performance of its functions. The committees may be continuing or temporary committees. The council shall determine the representation, membership, terms and organization of the committees and shall appoint committee members.

(7) A majority of the members of the council shall constitute a quorum for the transaction of business.

(8) Members of the council are not entitled to compensation, but at the discretion of the director may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties, subject to ORS 292.495.

(9) The council may accept contributions of funds and assistance from the United States Government or its agencies or from any other source, public or private, for purposes consistent with the purposes of the council.

(10) The Oregon Health Authority shall provide the council with such services and employees as the council requires to carry out its duties. [Formerly 409.619; 2015 c.318 §3]

Note: See note under 413.550.

413.556 Testing, qualification and certification standards for health care interpreters. The Oregon Council on Health Care Interpreters shall work in cooperation with the Oregon Health Authority to:

(1) Develop testing, qualification and certification standards for health care interpreters for persons with limited English proficiency and for persons who communicate in sign language.

(2) Coordinate with other states, the federal government or professional organizations to develop and implement educational and testing programs for health care interpreters.

(3) Examine operational and funding issues, including but not limited to the feasibility of developing a central registry and annual subscription mechanism for health care interpreters.

(4) Do all other acts as shall be necessary or appropriate under the provisions of ORS 413.550 to 413.558. [Formerly 409.621; 2015 c.318 §4]

Note: See note under 413.550.

413.558 Procedures for testing, qualifications and certification of health care interpreters; rules; fees. (1) In consultation with the Oregon Council on Health Care Interpreters, the Oregon Health Authority shall by rule establish procedures for testing, qualification and certification of health care interpreters for persons with limited English proficiency or for persons who communicate in sign language, including but not limited to:

(a) Minimum standards for qualification and certification as a health care interpreter, including:

(A) Oral and written language skills in English and in the language for which health care interpreter qualification or certification is granted; and

(B) Formal education or training in medical terminology, anatomy and physiology, medical interpreting ethics and interpreting skills;

(b) Categories of expertise of health care interpreters based on the English and non-English skills, or interpreting skills, and the medical terminology skills of the person seeking qualification or certification;

(c) Procedures for receiving applications and for examining applicants for qualification or certification;

(d) The content and administration of required examinations;

(e) The requirements and procedures for reciprocity of qualification and certification for health care interpreters qualified or certified in another state or territory of the United States or by another certifying body in the United States; and

(f) Fees for application, examination, initial issuance, renewal and reciprocal acceptance of qualification or certification as a health care interpreter if deemed necessary by the authority.

(2) Any person seeking qualification or certification as a health care interpreter must submit an application to the authority. If the applicant meets the requirements for qualification or

certification established by the authority under this section, the authority shall issue a letter of qualification or a certification to the health care interpreter.

(3) The authority shall work with other states, the federal government or professional organizations to develop educational and testing programs and procedures for the qualification and certification of health care interpreters.

(4) In addition to the requirements for qualification established under subsection (1) of this section, a person may be qualified as a health care interpreter only if the person:

(a) Is able to fluently interpret the dialect, slang or specialized vocabulary of the non-English language for which qualification is sought; and

(b) Has had at least 60 hours of health care interpreter training that includes anatomy and physiology and concepts of medical interpretation.

(5) A person may not use the title of "qualified health care interpreter" in this state unless the person has met the requirements for qualification established under subsections (1) and (4) of this section and has been issued a valid letter of qualification by the authority.

(6) In addition to the requirements for certification established under subsection (1) of this section, a person may be certified as a health care interpreter only if:

(a) The person has met all the requirements established under subsection (4) of this section; and

(b) The person has passed written and oral examinations required by the authority in English, in a non-English language or sign language and in medical terminology.

(7) A person may not use the title of "certified health care interpreter" in this state unless the person has met the requirements for certification established under subsections (1) and (6) of this section and has been issued a valid certification by the authority. [Formerly 409.623; 2015 c.318 §5]

Note: See note under 413.550.

413.560 Moneys received credited to account in Oregon Health Authority Fund. All moneys received by the Oregon Council on Health Care Interpreters under ORS 413.550 to 413.560 shall be paid into the Oregon Health Authority Fund and credited to an account designated by the authority. Such moneys shall be used only for the administration and enforcement of the provisions of ORS 413.550 to 413.560. [Formerly 409.625]

Note: See note under 413.550.

413.562 State of Oregon as employer of health care interpreters for purposes of collective bargaining only. (1) As used in this section, "health care interpreter" has the meaning given that term in ORS 413.550.

(2) For purposes of collective bargaining under ORS 243.650 to 243.806, the State of Oregon is the public employer of record of health care interpreters.

(3) Notwithstanding ORS 243.650 (19), health care interpreters are considered to be public employees governed by ORS 243.650 to 243.806. Health care interpreters have the right to form, join and participate in the activities of labor organizations of their own choosing for the purposes of representation and collective bargaining on matters concerning labor relations. These rights shall be exercised in accordance with the rights granted to public employees, with mediation and

interest arbitration under ORS 243.742 as the method of concluding the collective bargaining process. Health care interpreters may not strike.

(4) Notwithstanding subsections (2) and (3) of this section, health care interpreters are not for any other purpose employees of the State of Oregon or any other public body.

(5) The Oregon Department of Administrative Services shall represent the State of Oregon in collective bargaining negotiations with the certified or recognized exclusive representative of an appropriate bargaining unit of health care interpreters. The Oregon Department of Administrative Services is authorized to agree to terms and conditions of collective bargaining agreements on behalf of the State of Oregon.

(6) Notwithstanding ORS 243.650 (1), an appropriate bargaining unit for health care interpreters is a bargaining unit of all health care interpreters in this state. [2019 c.157 §1]

Note: 413.562 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

PAIN MANAGEMENT COMMISSION

413.570 Pain Management Commission; duties; staffing. (1) The Pain Management Commission is established within the Oregon Health Authority. The commission shall:

(a) Develop pain management recommendations;

(b) Develop ways to improve pain management services through research, policy analysis and model projects; and

(c) Represent the concerns of patients in Oregon on issues of pain management to the Governor and the Legislative Assembly.

(2) The pain management coordinator of the authority shall serve as staff to the commission. [Formerly 409.500]

Note: 413.570 to 413.599 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.572 Additional duties of commission. (1) The Pain Management Commission shall:

(a) Develop a pain management education program curriculum and update it biennially.

(b) Provide health professional regulatory boards and other health boards, committees or task forces with the curriculum.

(c) Work with health professional regulatory boards and other health boards, committees or task forces to develop approved pain management education programs as required.

(d) Review the pain management curricula of educational institutions in this state that provide post-secondary education or training for persons required by ORS 413.590 to complete a pain management education program. The commission shall make recommendations about legislation needed to ensure that adequate information about pain management is included in the curricula reviewed and shall report its findings to the Legislative Assembly in the manner required by ORS 192.245 by January 1 of each odd-numbered year.

(2) As used in this section, “educational institution” has the meaning given that term in ORS 348.105. [Formerly 409.510]

Note: See note under 413.570.

413.574 Membership of commission. (1) The Pain Management Commission shall consist of 19 members as follows:

(a) Seventeen members shall be appointed by the Director of the Oregon Health Authority. Prior to making appointments, the director shall request and consider recommendations from individuals and public and private agencies and organizations with experience or a demonstrated interest in pain management issues, including but not limited to:

(A) Physicians licensed under ORS chapter 677 or organizations representing physicians;

(B) Nurses licensed under ORS chapter 678 or organizations representing nurses;

(C) Psychologists licensed under ORS 675.010 to 675.150 or organizations representing psychologists;

(D) Physician assistants licensed under ORS chapter 677 or organizations representing physician assistants;

(E) Chiropractic physicians licensed under ORS chapter 684 or organizations representing chiropractic physicians;

(F) Naturopaths licensed under ORS chapter 685 or organizations representing naturopaths;

(G) Clinical social workers licensed under ORS 675.530 or organizations representing clinical social workers;

(H) Acupuncturists licensed under ORS 677.759;

(I) Pharmacists licensed under ORS chapter 689;

(J) Palliative care professionals or organizations representing palliative care professionals;

(K) Mental health professionals or organizations representing mental health professionals;

(L) Health care consumers or organizations representing health care consumers;

(M) Hospitals and health plans or organizations representing hospitals and health plans;

(N) Patients or advocacy groups representing patients;

(O) Dentists licensed under ORS chapter 679;

(P) Occupational therapists licensed under ORS 675.210 to 675.340;

(Q) Physical therapists licensed under ORS 688.010 to 688.201; and

(R) Members of the public.

(b) Two members shall be members of a legislative committee with jurisdiction over human services issues, one appointed by the President of the Senate and one appointed by the Speaker of the House of Representatives. Both members shall be nonvoting members of the commission.

(2) The term of office of each member is four years, but a member serves at the pleasure of the appointing authority. Before the expiration of the term of a member, the appointing authority shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the appointing authority shall make an appointment to become immediately effective for the unexpired term.

(3) Members of the commission are not entitled to compensation or reimbursement for expenses and serve as volunteers on the commission. [Formerly 409.520; 2019 c.13 §42]

Note: See note under 413.570.

413.576 Selection of chairperson and vice chairperson; requirements for commission meetings. (1) The Director of the Oregon Health Authority shall select one member of the Pain

Management Commission as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the director determines.

(2) A majority of the voting members of the commission constitutes a quorum for the transaction of business.

(3) The commission shall meet at least once every six months at a place, day and hour determined by the director. The commission also shall meet at other times and places specified by the call of the chairperson or of a majority of the members of the commission. [Formerly 409.530]

Note: See note under 413.570.

413.580 Pain Management Fund. There is established the Pain Management Fund in the Oregon Health Authority Fund established under ORS 413.101. All moneys credited to the Pain Management Fund are continuously appropriated for the purposes of ORS 413.570 to 413.599 to be expended by the Pain Management Commission established under ORS 413.570. [Formerly 409.540]

Note: See note under 413.570.

413.582 Acceptance of contributions. The Pain Management Commission may accept contributions of funds and assistance from the United States Government or its agencies or from any other source, public or private, and agree to conditions thereon not inconsistent with the purposes of the commission. All such funds shall be deposited in the Pain Management Fund established in ORS 413.580 to aid in financing the duties, functions and powers of the commission. [Formerly 409.550]

Note: See note under 413.570.

413.590 Pain management education required of certain licensed health care professionals; duties of Oregon Medical Board; rules. (1) An approved pain management education program described in ORS 413.572 (1)(c) or an equivalent pain management education program as described in ORS 675.110, 677.228, 677.510, 678.101, 684.092, 685.102 or 689.285 must be completed by:

(a) A physician assistant licensed under ORS chapter 677;

(b) A nurse licensed under ORS chapter 678;

(c) A psychologist licensed under ORS 675.010 to 675.150;

(d) A chiropractic physician licensed under ORS chapter 684;

(e) A naturopath licensed under ORS chapter 685;

(f) An acupuncturist licensed under ORS 677.759;

(g) A pharmacist licensed under ORS chapter 689;

(h) A dentist licensed under ORS chapter 679;

(i) An occupational therapist licensed under ORS 675.210 to 675.340;

(j) A physical therapist licensed under ORS 688.010 to 688.201; and

(k) An optometrist licensed under ORS chapter 683.

(2) The Oregon Medical Board, in consultation with the Pain Management Commission, shall identify by rule physicians licensed under ORS chapter 677 who, on an ongoing basis, treat patients in chronic or terminal pain and who must complete one pain management education program established under ORS 413.572. The board may identify by rule circumstances under which a requirement under this section may be waived. [Formerly 409.560; 2019 c.3 §2]

Note: See note under 413.570.

413.592 [Formerly 409.565; repealed by 2015 c.70 §11]

413.599 Rules. In accordance with applicable provisions of ORS chapter 183, the Pain Management Commission may adopt rules necessary to implement ORS 413.570 to 413.599. [Formerly 409.570]

Note: See note under 413.570.

TRADITIONAL HEALTH WORKERS COMMISSION

413.600 Traditional Health Workers Commission. (1) There is established within the Oregon Health Authority the Traditional Health Workers Commission.

(2) The Director of the Oregon Health Authority shall appoint the following 23 members to serve on the commission:

(a) Thirteen members, of which a majority or at least seven must be appointed from nominees selected by the Oregon Community Health Workers Association, who represent traditional health workers, including at least one member to represent each of the following:

(A) Community health workers, as defined in ORS 414.025;

(B) Personal health navigators, as defined in ORS 414.025;

(C) Peer wellness specialists, as defined in ORS 414.025;

(D) Peer support specialists, as defined in ORS 414.025;

(E) Doulas;

(F) Family support specialists, as defined in ORS 414.025; and

(G) Youth support specialists, as defined in ORS 414.025;

(b) One member who represents the Office of Community Colleges and Workforce Development;

(c) One member who is a nurse who represents the Oregon Nurses Association;

(d) One member who is a physician licensed in this state;

(e) One member selected from nominees provided by the Home Care Commission;

(f) One member who represents coordinated care organizations;

(g) One member who represents a labor organization;

(h) One member who supervises traditional health workers at a community-based organization, local health department, as defined in ORS 433.235, or agency, as defined in ORS 183.310;

(i) One member who represents community-based organizations or agencies, as defined in ORS 183.310, that provide for the training of traditional health workers;

(j) One member who represents a consumer of services provided by health workers who are not licensed by this state; and

(k) One member who represents providers of Indian health services that work with traditional health workers qualified under ORS 414.665, a federally recognized tribe or a tribal organization.

(3) In appointing members under subsection (2) of this section, the director shall consider whether the composition of the Traditional Health Workers Commission represents the geographic, ethnic, gender, racial, disability status, gender identity, sexual orientation and economic diversity of traditional health workers.

(4) The term of office of each member of the commission is three years, but a member serves at the pleasure of the director. Before the expiration of the term of a member, the director shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the director shall make an appointment to become immediately effective for the unexpired term.

(5) A majority of the members of the commission constitutes a quorum for the transaction of business.

(6) Official action by the commission requires the approval of a majority of the members of the commission.

(7) The commission shall elect one of its members to serve as chairperson.

(8) The commission shall meet at times and places specified by the call of the chairperson or of a majority of the members of the commission.

(9) The commission may adopt rules necessary for the operation of the commission.

(10) A member of the commission is entitled to compensation and expenses as provided in ORS 292.495. [2013 c.752 §2; 2015 c.366 §87; 2017 c.618 §1; 2019 c.123 §1]

Note: 413.600 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

MISCELLANEOUS

413.800 Emergency planning. (1) As used in this section:

(a) "Adult foster home" has the meaning given that term in ORS 443.705.

(b) "Health care facility" has the meaning given that term in ORS 442.015.

(c) "Residential facility" has the meaning given that term in ORS 443.400.

(2) Every adult foster home, health care facility and residential facility licensed or registered by the Oregon Health Authority shall:

(a) Adopt a plan to provide for the safety of persons who are receiving care at or are residents of the home or facility in the event of an emergency that requires immediate action by the staff of the home or facility due to conditions of imminent danger that pose a threat to the life, health or safety of persons who are receiving care at or are residents of the home or facility; and

(b) Provide training to all employees of the home or facility about the responsibilities of the employees to implement the plan required by this section.

(3) The authority shall adopt by rule the requirements for the plan and training required by this section. The rules adopted shall include, but are not limited to, procedures for the evacuation of the persons who are receiving care at or are residents of the adult foster home, health care facility or residential facility to a place of safety when the conditions of imminent danger require relocation of those persons. [2011 c.720 §41]

Note: 413.800 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 413 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

413.825 [Formerly 432.312; 2015 c.651 §6; renumbered 692.415 in 2015]

413.850 [2011 c.720 §42; renumbered 413.195 in 2013]

413.990 [Repealed by 1953 c.500 §12]
