2018 Guidelines Update – Changes to Keep Pace with Clinical Practices?

Presentation for HFMSNJ
Thursday June 21, 2018
The views and opinions expressed in this presentation are the opinion of the speaker and may not be the official position of FGI or the Health Guidelines Revision Committee.

Who was involved in development of the 2018 Guidelines?
2018 HGRC
100+ Multidisciplinary Committee

20% - Architects
18% - Medical professionals
16% - State AHJs
13% - Engineers
10% - HC administrators/HC org. reps
8% - Federal AHJs (IHS, CMS, HUD, VA)
7% - Infection control experts + NIH/CDC
4% - Construction professionals
4% - Interior designers

FGI Process Overview

Consensus-based process for Guidelines development using:
- Collective multidisciplinary experience
- Professional stakeholder consensus, including many AHJs (no manufacturers vote on proposals)
- Public review process
- Clinical and evidence-based research
- Continual improvement process

Every new edition of the FGI Guidelines is different and an “evolution” from previous editions.
What States use the *Guidelines* and what edition have they adopted?
This is not us...

FGI website: a way to keep current with FGI and Guidelines activities
FGI Research Initiatives

AHRQ-Funded – Safety Risk Assessment Toolkit

Safety Risk Assessment Toolkit for Hospitals

- Funded by the Agency for Healthcare Research and Quality (AHRQ) and developed by the Facility Guidelines Institute (FGI) and the Center for Health Design (CHD)
- Developed a tool for integrating patient and staff safety into the design process
- Questionnaire format
- Interdisciplinary teams from across the U.S.
- Initial presentation at the ASHE PDC March 2015 preconference program
AHRQ-Funded – Safety Risk Assessment Toolkit

Questionnaire to help project team reduce risk for:

- Falls (including noise causing poor sleep)
- Medication errors (noise and distraction)
- Behavioral health (noise reduction impact)
- Hospital-acquired infections
- Security
- Patient handling and movement
- Patient immobility (hospital only)

2014 Cost Estimate Report

Estimated Cost of Applying the 2014 vs. the 2010 FGI Guidelines for Design and Construction Requirements to Hospitals and Outpatient Facilities

Executive Summary

The Facility Guidelines Institute (FGI) published the 2014 FGI Guidelines for Design and Construction of Hospitals and Outpatient Facilities in March 2015. Any state or other jurisdictions considering adopting new editions of codes, they receive anecdotal comments about large costs associated with updated requirements. Many states require an economic impact analysis as part of their code adoption
2014 Edition First Cost Impact Review

- HGRC Cost/Benefit Committee in conjunction with ASHE
- Review of Hospital/Outpatient document to identify the first cost impact of implementing the 2014 edition (approx. 2% increase in first cost with no credits for cost reductions)

2018 Edition Benefit-Cost Impact Review

- EVERY 2018 proposal for change was reviewed by the HGRC for clinical and operational benefit. The Benefit/Cost Committee also reviewing for benefit, first cost, and life cycle cost of major changes.

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**2014 Cost/Benefit Study Algorithm**

*ASHE 2014 Study – Added up + first cost part of the algorithm only*

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Cost/Benefit Algorithm for 2018 Analysis

FGI is using the entire algorithm vs. just first cost

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2018 Defining Minimum
“Minimum” Guidelines Goals

- Multidisciplinary participation
- Not controlled by special interest, for-profit manufacturing
- Non-representational participation – every member expected to vote their conscience, not their organizational party line
- Rigorous consensus process
- Emphasis on evidence – importance of expert opinion
- Provide minimums – appendix references for beyond minimum and information for applying the requirements
- Matching design to function
- “Predicting” the future – staying flexible, contemporary

Minimum is Difficult to Define

- Risk of being too minimal (creates opportunity for harm)
- Consider risk/benefit for new minimums
- The minimum benchmark changes over time
- Cost is a reality in determining Minimum Standards
2018 Guidelines

At the end of the 2014 cycle, the FGI Board undertook two colloquiums focused on the future of health care and the Guidelines.

These colloquiums brought together a diverse group of health care futurists who were tasked with:
1) Envisioning the range of health care environments and trends that may emerge by 2026, and
2) Helping FGI lay out a roadmap of the steps we need to take to stay relevant over that time period.

2018 Guidelines

Colloquium recommendations:
• Split the standard into two parts:
  ➢ Fundamental Requirements – Minimum/baseline standards that can be adopted as code by AHJs
  ➢ Beyond Fundamentals – Emerging and/or best practices that exceed basic requirements
• Focus on primary care/outpatient facilities for the coming revision cycle as the trend in health care delivery is continuing to move in that direction.
Proposed New Structure

THE
LOW ACUITY PATIENT POD
Happening Now

2014 – 2016
ACEP National Conventions
Chicago. Boston. Las Vegas
Low Acuity Patient Pod
Variations & Sizing

DIMENSIONAL CONTROL
An overview of major topics that were addressed and some of the proposed changes discussed
Hot Topics for 2018

- Design/clearances to accommodate patients of size
- Pre- and post-procedure patient care areas – flexibility to combine areas and correct ratios when doing so
- Procedure and operating room sizes that reflect space requirements for anesthesia team and equipment

Copyright FGI 2014

Hot Topics for 2018

- Classification system for imaging rooms
- Guidance for when exam/treatment, procedure, and operating rooms are needed
  - Clearances and spatial relationships
  - Locations for procedure types

Copyright FGI 2014
Hospital and Outpatient Guidelines
Additional Major Topics Addressed

- Design of telemedicine spaces
- Sterile processing facilities
- Mobile/transportable medical unit revisions

Telemedicine Services

- Requires telemedicine space when clinical telemedicine services are provided
- May be a bay, cubicle, or room, permitted to be used for other purposes: e.g., patient room, physician’s office, conference room
- Appendix recommendations on:
  - Room features
  - Placement of cameras and microphones
- Addresses privacy, acoustics, lighting, site identification (for reimbursement and orientation)
Accommodations for Patients of Size

Determining “patient of size”:
- Patient’s weight
- Distribution of the patient’s weight throughout the body
- Patient’s height

In the Hospital document: Bariatric nursing unit removed from facility chapters and accommodations for patients of size added as a common element to address the need for serving patients of size throughout a health care facility. Accommodations for patients of size also added to Outpatient and Residential documents.

Bariatric Patient Environment

Minimum Clearances Required for Bed to Wheelchair Transfer Using Floor-based Full Body Sling

Caregivers safely transfer Patient from Lift to chair.
Bariatric Patient Environment

Minimum Clearances Required for Bed to Chair Transfer Using Ceiling Lift

Caregivers safely transfer patient from bed to lift….

……to chair

Pre- and Post-Procedure Patient Care Areas

- Direct access to the semi-restricted area without crossing unrestricted public corridors
- Ability to combine all patient care stations (pre-, Phase I, Phase II) in one area
  - Must meet the most restrictive requirements
  - Where combined into one area, at least two patient care stations per procedure, operating, or Class 2 or Class 3 imaging room
Pre- and Post-Procedure Patient Care Areas

Stations can be bays, cubicles, or single-patient rooms.

- Clearances
  - Bays (5 feet between gurneys, 3 feet between sides and adjacent walls, and 2 feet from foot of bed to the cubicle curtain)
  - Cubicles (3 feet between sides and adjacent walls, 2 feet from foot of bed to the cubicle curtain)
  - Where bays/cubicles face each other, need 8-foot aisle
  - Room (3 feet between sides and foot to the wall)

Pre- and Post-Procedure Patient Care Areas

- If separate pre-procedure room
  - Minimum of one patient care station per imaging, procedure, or operating room

- Phase I PACU
  - One per operating room (was 1.5)

- Phase II recovery room
  - Minimum of one per imaging, procedure, or operating room
Invasive Procedure Definition

A procedure that is performed in an aseptic surgical field and penetrates the protective surfaces of a patient’s body. May fall into one or more of the following categories:

- Requires entry into or opening a sterile body cavity
- Involves insertion of an indwelling foreign body
- Includes excision and grafting of burns that cover more than 20 percent of total body area
- Does not begin as an open procedure but has a risk, as determined by the physician, of requiring conversion to an open procedure

Why does it matter?

- Invasive – Operating room
- Patient care that may require sterile instruments but does not require OR environmental controls – Procedure room
- Non-invasive - Exam room Treatment room
Minimum Room Sizes

Operating Rooms

- Minimum clear floor area
  - Hospitals: Still 400 sq. ft. or 600 sq. ft. for special procedures
  - Outpatient: 255 sq. ft. unless general anesthesia administered, then 270 sq. ft.
CLEARANCE ZONE DIAGRAM
OPERATING ROOM – OUTPATIENT – PROPOSED FOR COMMENT

OUTPATIENT OPERATING ROOM

- Patient area
- Sterile field where scrub and physician work
- Circulation pathway where the circulator walks to perform duties. Cannot walk into sterile field.
- Movable equipment zone where the required movable equipment is stored and provides for door swing and opening of fixed drawers or opening of door and drawers on carts
- Anesthesia 6’ x 8’ work zone
- Gray and White area is 2’ area shared between anesthesia and circulator
- CFA Clear Floor Area - 400 SF

3’ X 7’ Gurney for planning purposes
3’ at Sides & Foot – Sterile Field
3’ at Sides, 2’ at Foot – Circulation
2’-6” at Sides, 2’ at Foot – Equipment
20’ Minimum Width, 400 SF Minimum CFA

Operating Rooms

- Clearances for 400-sq-ft OR:
  - 8 feet 6 inches on each side
  - 6 feet at the head
  - 7 feet at the foot
- Monolithic ceilings still required
Procedure Room Definition

• For procedures that do NOT meet the glossary definition of “invasive procedure”
  – Can be performed outside the restricted space of the surgery department or facility
  – May require use of sterile instruments or supplies
  – Requires some environmental controls but not OR-level environmental controls

(Procedures performed in former Class A OR occur in procedure rooms.)

Procedure Room

• Semi-restricted area that is accessed from either semi-restricted or unrestricted corridor
• Space requirements
  – Clear floor area: reduced to 130 square feet
  – Clearances: 3 feet 6 inches on sides of table and 3 feet at head and foot of table
  – EXCEPTIONS where general anesthesia administered:
    • Clear floor area: 160 square feet
    • Clearances: 6 feet at head
CLEARANCE ZONE DIAGRAM
PROCEDURE ROOM – INPATIENT & OUTPATIENT
(NO Anesthesia Work Area)

- Patient area
- Circulation pathway where the circulator walks to perform duties. Cannot walk into sterile field.
- Movable equipment zone where the required movable equipment is stored and provides for door swing and opening of fixed drawers or opening of door and drawers on carts

- 3’-0” Clearance at Head & Foot
- 3’-6” Clearance at Sides
- 130 SF CFA

CLEARANCE ZONE DIAGRAM
PROCEDURE ROOM – INPATIENT & OUTPATIENT
(INCLUDING Anesthesia Work Area)

- Patient area
- Circulation pathway where the circulator walks to perform duties. Cannot walk into sterile field.
- Movable equipment zone where the required movable equipment is stored and provides for door swing and opening of fixed drawers or opening of door and drawers on carts
- Anesthesia 6’ x 8’ work zone
- Gray and White area is 2’ area shared between anesthesia and circulator
- CIA Clear Floor Area - 160 SF

- 3’ X 7’ Gurney for planning purposes
- 6’ x 8’ Anesthesia Work Zone at Head
- 2’ x 8’ at Perimeter, may serve as Circulation
- 3’-0” Clearance at Head & Foot, 3’-6” Clearance at Sides
- 130 SF + 30 SF (3’ x 10’) = 160 SF
Endoscopy

• **Endoscopy procedure rooms** shall meet the requirements for procedure rooms…except as follows:
  – Minimum clear floor area of 180 sq. ft. (reduced from 200)
  – Clearance of 5 feet at each side
  – Clearance of 3 feet 6 inches at head and foot
• **Endoscope processing room** is a semi-restricted area
  – Both decontamination and clean work areas with one-way traffic flow
  – Entrance and exit permitted to be from the procedure room

Classification of Imaging Room Types

• Class 1 imaging room
  – Diagnostic in nature (CT, MRI, fluoroscopy)
  – Services that utilize natural orifice entry
  – Accessed from an unrestricted area
  – Basic environmental controls (ventilation, surfaces)
Classification of Imaging Room Types

• Class 2 Imaging room
  – Procedures:
    • Diagnostic and therapeutic
    • Electrophysiology
    • Endoscopic
  – Accessed from an unrestricted or semi-restricted area
  – Some environmental controls for procedures such as cardiac cath

Classification of Imaging Room Types

• Class 3 imaging room and operating room
  – Invasive procedures
  – Any Class 2 procedure the physician identifies with a risk of needing conversion to an open procedure
  – Accessed from a semi-restricted area
  – Environmental controls of an operating room
Sterile Processing

Facilities outside a sterile processing department shall comply with all requirements for two-room sterile processing areas unless the equipment is limited to a table-top or similar-sized sterilizer, in which case a single room is acceptable.

Sterile Processing

- Sterile processing areas shall:
  - Be a semi-restricted area
  - Support a one-way traffic pattern
  - Have at least two entrances
  - Consist of a decontamination room and a clean workroom, separated by a wall with a door or pass-through
One-Way Flow

Hospital Guidelines
Other Notable Changes

- Single-bed CCU rooms
- Sexual assault forensic exam room
- Geriatric treatment room in ED
- Technology distribution room size
Critical Care Unit

- Each patient care station shall be a single-patient room.
- In renovation, cubicles would be permitted.

Sexual Assault
Forensic Exam Room

If provided, must meet the requirements of a single-patient exam room. SANE room contains:
- Pelvic examination bed/table
- Lockable storage area for forensic collection kits
- Private toilet and shower
- Readily accessible consultation room
Geriatric Treatment Room in ED

Focus on reducing risk of patient falls

Provides brief guidance on:
• Surfaces & furnishings
• Flooring and furniture

Technology Distribution Room Size

All TDRs shall provide a minimum 3-foot clearance on all sides of the equipment rack(s).
Part 1: Introduction
Part 2: Outpatient Facility Types
Chapter 2.1: Common Elements for OP Facilities

Facility type chapters:
- Will include chapter on freestanding emergency departments from Hospital book
- Mobile/transportable units will also be included in the Hospital book

Common Elements
- Patient care and diagnostic areas (clinical rooms, telemedicine, imaging, etc.)
- Patient support areas (pharmacy, lab, linen, sterile processing)
- Building support areas (environmental services, waste management, materials management)
- Public and administrative areas
- Architectural details, surfaces, and furnishings
- Building systems
- Acoustic tables tailored for outpatient facilities
Outpatient Guidelines
Other Notable Changes

• Two approaches to applying requirements to facility projects
• Attention to flexibility for small projects
• Acknowledgment some facilities may be part of larger buildings owned by others
• Adjustments to building system requirements
• Consistent waiting room requirements for outpatient facilities
• Mobile/transportable medical unit revisions

Moving Forward…..
Onward to 2018…and multiple documents

• Hospitals
• Outpatient Facilities
• Residential Health, Care, and Support Facilities
• Sound & Vibration 3.0
• Beyond Fundamentals

Q & A

Thank you for joining us today!