MINUTES
HEALTHCARE INTERPRETATIONS TASK FORCE
Tuesday June 12, 2012
MANDALAY BAY CONVENTION CENTER
REEF A
Las Vegas, NV

1. The meeting was called to order at 1:15 PM. (See Enclosure A [Agenda])

2. Introduction of members and guests was completed. Those in attendance included:

<table>
<thead>
<tr>
<th>MEMBER</th>
<th>REPRESENTING</th>
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<tbody>
<tr>
<td>Ken Bush* Maryland State Fire Marshal’s Office</td>
<td>International Fire Marshals Association (IFMA)</td>
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<tr>
<td>Stephen Christopher*</td>
<td>U.S. Department of Health and Human Services Rep. Indian Health Service (IHS)</td>
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<td>Dave Dagena, Wentworth-Douglas Hospital</td>
<td>American Society for Healthcare Engineering (ASHE)</td>
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<td>Philip Hoge*</td>
<td>US Army Corps of Engineers</td>
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<td>David Klein* Office of the Deputy Under Secretary for Health for Operations and Management</td>
<td>Department of Veterans Affairs</td>
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<td>George Mills*</td>
<td>The Joint Commission</td>
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<td>Robert Solomon</td>
<td>National Fire Protection Association</td>
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<tr>
<td>Chad Beebe (ALT to D. Dagena)</td>
<td>American Society for Healthcare Engineering (ASHE)</td>
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<td>Gregory Harrington (ALT to R. Solomon)</td>
<td>National Fire Protection Association</td>
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<tr>
<td>Peter Larrimer (ALT to D. Klein)</td>
<td>U.S. Department of Veterans Affairs Rep. Department of Veterans Affairs (VA)</td>
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<td>Brian Prediger (ALT to P. Hoge)</td>
<td>US Army Medical Command</td>
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<tr>
<td>Richard Strub (ALT to T. Jaeger)</td>
<td>American Health Care Association (AHCA)</td>
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* Voting AHJ Member

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<th>GUEST</th>
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<tr>
<td>Briton Berek</td>
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<td>Rich Fasano</td>
<td>Russell Phillips &amp; Associates</td>
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<td>Virgil Hall</td>
<td>Department of Veterans Affairs</td>
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<td>William Koffel</td>
<td>Koffel Associates</td>
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<td>Robert Mayer</td>
<td>Rothschild Foundation</td>
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3. **Review of Questions.** No questions were received in advance of the meeting. However, a number of items had been put fourth during the meeting.

**A. Locking Protocols for Active Shooter and Similar Events.** The extent that the 2000 or 2012 edition of NFPA 101 governs a locking scenario where major parts (or all) of a hospital would have to be in a lock down mode was discussed. Facilities have routine procedures in place to lock access (ingress) to spaces but the traditional clinical needs and even the newer security needs have not contemplated. There was general agreement that this scenario has not been contemplated in the code. Questions surrounding this included: How prevalent is this scenario? What events (shooter, contagion release) might trigger this? Who would make the decision to do this—hospital personnel, local law enforcement? Who would have ability to unlock the doors? It was noted that US Army facilities are installing remotely controlled electric locks on doors to limit access and egress to spaces. George Mills (TJC) will develop some language prior to the meeting of the NFPA TC on Healthcare Occupancies meeting this August. Time permitting, the TC may be able to develop a First Revision (FR) or a Committee Input (CI).

**B. Are Windows Required in ICU Areas (NFPA 101:18/19.3.8).** Window provisions in NFPA 101 have gone from windows being operable, having a window (but not operable), to there being no requirement for any type of window. The details for windows (where required, type, size) are appropriately covered in the FGI guidelines. The HITF believes it is better to allow this type of criteria to remain in the FGI Guidelines.

**C. Wheeled Equipment in Corridors and Access to Control Equipment.** This discussion started simply as “Is a wheeled gurney parked in front of a pull station obstructing access?” Various portions of NFPA 101 (9.6.2) and NFPA 72 (17.14.5) speak to having access to the pull station. The discussion extended to other types of control equipment like medical gas control valves or portable fire extinguishers being partially blocked by equipment. The nature and type of the wheeled equipment is equally important. Some equipment types could be easily moved by a staff member such as a gurney or a patient lift. Other equipment might require a key to energize the drive wheels on the equipment thus that could not be easily moved out of the way. After discussing a range of scenarios and equipment, the HITF developed a question and issued a position. *(See Enclosure B-1 [Issued Interpretation]*)

| Question: | Is a wheeled item permitted to be parked in front of fire protection or service equipment?
| Answer: | Yes, provided that the fire protection or service equipment remains conspicuous and that the wheeled item can be immediately moved to make the fire protection or service equipment accessible. |
D. Placement of large screen monitors (greater than 36 inches wide and leaning out at the ceiling 6 – 8 inches down to 4 inches thick (width) at the handrail height) in corridors. Since the 2012 edition of NFPA 101 (18/19.2.3.4) offered more options for placement of fixed equipment in corridors, equipment such as large wall mounted monitors (flat screen panels) which have been prevalent, and whose use continues to increase, might be viewed as an obstruction in the corridor. The HITF agreed that there appears to be a space in which the monitors can be mounted to the wall without compromising the projection rules. That space would be bounded by the allowance for projections that maintain a ceiling clearance of at least 6’8” (NFPA 101: 7.1.5.1), the 6” allowable projection from the wall and the need to keep any such projections at least 38” above the floor (NFPA 101: 18/19.2.3.4 (2)).

The HITF agreed to develop a diagram to describe this arrangement and be letter balloted on the following question and response along with the companion diagram. (NOTE: Once this ballot is completed, the results will be reported.)

**Question:** Are large flat screen or similar monitors permitted to be mounted to the wall in a corridor of a healthcare occupancy?

**Answer:** Yes, provided that the equipment is mounted in such a way so as to not violate the provisions of NFPA 101 (2012) Sections 7.1.5.1 and 18/19.2.3.4(2). See accompanying diagram.
E. Water Coolers in Corridors. A member raised a question asking if the new rules in NFPA 101, 2012, 18/19.2.3.4(5) for fixed furniture could be extrapolated to things like water coolers. Attempting to extend this rule to anything other than fixed furniture would not be appropriate. The language in the 2012 code is very precise for what it is referring to and the technical committee on healthcare occupancies did not have any discussions regarding placement of other than fixed furniture.

F. Wiring Supported by/on Sprinkler Pipe. The discussion is-is there any amount of wire or cable that can be attached to, or supported by the sprinkler pipe and hangers? NFPA 13 and NFPA 25 have very restrictive language that prohibits anything from being attached to the pipe or hangers unless such equipment relates to operation of the system for example detection wiring used as part of a preaction system. There is no amount or type of material that can be attached to the pipe or the hangers.

G. Placement of Communication, Video and Security Equipment in Exit Stairs. NFPA 101, 2012, 7.1.3.2.1 offers a list of items that can be in the exit enclosure or penetrate the exit enclosure. Video equipment for security purposes and cell phone/radio repeaters are among the items now being placed in exit stairs. Stair descent devices, portable fire extinguishers and related types of safety oriented equipment are among the equipment that might be found in the stair. The best guidance that the HITF can offer is to make sure that the width of the stair is not reduced and that none of the installed equipment can interfere with the use of the exit (See NFPA 101, 2012, 7.1.3.2.3.)

H. Placement of Decorative Objects in Exit Stairs. Workplace health benefit programs are encouraging broader use of stairs by employees. This has resulted in ‘sprucing up’ the stairs with brighter colors and the addition of decorative materials. The addition of objects in the exit stair would fall under the requirements of NFPA 101, 2012 Sections 7.1.3.2.3, 7.1.4 and 7.3.4. Provided the addition of any other items permits the criteria of those sections to be maintained, there is no specific limit on what can be added to that exit stair.

4. Old Business. At the June 2011 HITF meeting, a Task Group was asked to look at the increasing use of pass through cabinets in healthcare environments. These cabinets permit replenishment of supplies from the corridor side and then they can be accessed from inside the patient room. At present, there is no information in NFPA 101 that expressly deals with these cabinets. The following represents the report of the Task Group. Several Public Inputs (PIs) on this topic have been received for the 2015 editions of NFPA 101/NFPA 5000 and will be discussed at the meetings in August of this year. The Task Group report offers background material and the questions that need to be addressed when developing the requirements.

Healthcare Architects continue to look for innovative methods to increase the functional use of space in an attempt to increase efficiency and make use of space in a creative way. Recently a number of designs have included openings in the construction of corridor walls into patient rooms in a method that creates a pass-through opening for passing/storing supplies and materials such as bedding, towels, etc. from the corridor side of the wall into the patient room. These pass-through cabinets have been observed in a variety of sizes which include full wall height units to half wall height units. These cabinets are typically provided with a door of various construction provided on the corridor side of the wall, and may or may not be provided with a similar door on the patient room side of the wall. Cabinet doors are provided with various methods of securing
the door in the closed position including latches and/or deadbolt type locks. As healthcare staff makes their rounds down the corridor, they open the doors and stock the cabinets from the corridor side of the wall.

There is concern that these openings may not meet the requirements for corridor wall construction, corridor doors, and permitted openings in corridor walls. As the doors to these units are not typically used by occupants to enter/exit a room, there is a concern that the doors may not always be secured closed to resist the passage of smoke and would not be routinely checked in a fire emergency to insure that they are secured, endangering the occupants of the rooms by permitting smoke to enter the room from the corridor, or permit smoke from a room to enter the corridor.

**Question 1:** Are pass-through cabinets or similar arrangements permitted in corridor walls of patient rooms or corridor walls in smoke compartment containing patient rooms?

**Question 2:**
If pass-through cabinets are permitted, what are the requirements of the doors to the cabinets:
- a. Are doors required on both the corridor side and room side of the corridor wall?
- b. Is the door, or doors required to be self-closing?
- c. Is the door, or doors required to have positive latching hardware?
- d. What are the construction and installation requirements of the door or doors?

**Question 3:**
If pass through cabinets are permitted, is there a size limitation to the opening in the corridor wall?

**Question 4:**
If pass-through cabinets are permitted, is sprinkler protection required inside of the cabinet?

5. New Business

**A. Rothschild Foundation.** Robert Mayer of the Rothschild Foundation provided an overview of the Foundation and some of the Foundation’s goals related to healthcare (See Enclosure C-1). The session was opened up to all attendees to brainstorm some ideas and concepts where more work/research/knowledge is desired. A list of items was developed. The Rothschild Foundation will be reviewing the items and ideas identified and will then make a determination what role the Foundation might have to pursue some of the ideas presented. (See Enclosure C-2 for the list)

**B. 2012 NFPA Healthcare Summit.** The 2012 Summit was held on March 28, 2012. Eight speakers discussed a range of subjects from long term and acute care, ambulatory healthcare, assisted living and emergency management/response to disaster events. Both the attendees and TC members were given some insight into current and future challenges as well as current solutions that are being considered. The proceedings of the Summit can be found on the Foundations webpage:
C. Organizational Updates

- VA. The ongoing process of updating the VA criteria to recognize the most current/recent editions of NFPA codes and standards continues. Staff has also been involved in the HUD- VASH (Veterans Affairs Supportive Housing) program to insure that the residential and housing facilities used in the program are code compliant.

- IHS. IHS has moved to the 2012 LSC for their facilities. Have been reviewing and suggesting updates to BIM on an as needed basis. Recently completed an update on the IHS Construction Guidance Document.

- AHCA. Continues to push for household model in long term care environments. The organization also is looking more at the private pay market due to cutbacks in Medicare/Medicaid payments. Approximately 90 percent of AHCA clients are covered under icare/Medicaid.

- DOD. Hospital and medical building projects are ongoing worldwide. Reduction in construction spending for the medical program is expected to see cuts in FY '15 thus a slowdown is to be anticipated. The UFC criteria has not been updated as of yet however, the Army Medial Command has implemented the 2012 edition of the codes.

- ASHE. Currently conducting a survey to determine what percentage of hospitals are not fully sprinkler protected.

- IFMA. Maryland State Fire Marshals office looking closely at occupants who might best be classified for residential board care or even healthcare but who are showing up in more residential type settings. Seeing an increased trend of outpatient surgical centers (ambulatory healthcare) being placed in mercantile areas and spaces.

- TJC. Starting to evaluate and grade equivalencies based on the March 9, 2012 CMS S&C letter.

- NFPA. In the process of finalizing a comparison of NFPA 101 2000 edition and 2012 edition for CMS to assist them with preparation of the preamble for possible future rule making. The new NFPA process was used at the NFPA 101/5000 meetings in May. It is a learning curve for staff and TC members but everyone is adjusting very well.

D. Expanding HITF Roster. NFPA received an email from the code consultant to the American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP) asking to join the HITF. The consultant is not an employee of AOA/HFAP and a letter designating him as their representative has been requested. Once received, the HITF will schedule a conference call to discuss the request and then to determine the appropriate course of action based on the HITF bylaws.

E. HITF Member Letter to CMS. In October of 2011, CMS published a notice in the federal register asking for comment on adoption of NFPA 101-2012 edition. While some of the
individual organizations submitted a letter to CMS in response to the FR notice, the question was raised if a joint letter could come from the HITF members. A similar, jointly authored and signed letter came for the HITF organizations in 1997 which encouraged CMS (HCFA) to adopt the 1997 edition of NFPA 101. While the joint letter idea has merit, having the federal agency members sign onto such a letter is problematic as it would appear to be a policy position. As an alternative, the private sector member organizations (AHCA, ASHE/AHA, IFMA, TJC, NFPA) agreed to pursue a joint letter. NFPA will draft the letter for consideration and circulate to the others for comment. It may be possible to have something come from the HITF Chair (Solomon) encouraging CMS to adopt the 2012 edition of NFPA 101 but that still may be problematic for the federal agency representatives.

6. **Next Meeting.** Members are asked to provide any potential agenda items to NFPA by October 15, 2012. Depending on what is received, an in person or conference call meeting will be scheduled. An in person meeting of the HITF will be scheduled for Tuesday, June 11, 2013.

7. **Adjournment.** The meeting adjourned at 5:45 PM.
ENCLOSURE A
Healthcare Interpretations Task Force
AGENDA
Mandalay Bay Convention Center
Room – Reef “A”
Las Vegas, NV

June 12, 2012
1:00 P.M. to 6:00 P.M.

1. Call to Order 1:00 P.M.

2. Introduction of Members and Guests.


4. Old Business.
   • Pass Through Cabinets: Task Group Report
     (Mills, Dagenais, Erickson, Merrill)

5. New Business.
   • Collaborative Opportunities
     o The Rothschild Foundation – Robert Mayer, President
   • 2012 – NFPA Health Care Summit.
   • Organization Updates.
   • Expanding HITF Roster.
     o American Osteopathic Association

6. Date / Location for Next Meeting.

7. Adjournment by 6:00 PM.
ENCLOSURE B
HITF INTERPRETATION
JUNE 2012 NO. 1

DOCUMENT TO BE INTERPRETED: NFPA 101

EDITON: 2009

SUBJECT: A Parked Wheeled Gurney; obstructing access

| Question: Is a wheeled item permitted to be parked in front of fire protection or service equipment? |
| Answer: Yes, provided that the fire protection or service equipment remains conspicuous and that the wheeled item can be immediately moved to make the fire protection or service equipment accessible. |

Important Notice: This correspondence is not a Formal Interpretation issued pursuant to NFPA Regulations. Any opinion expressed is the personal opinion of the author, and does not necessarily represent the official position of the NFPA or its Technical Committees. In addition, this correspondence is neither intended, nor should be relied upon, to provide consultation or services.
ENCLOSURE C1
Why is person-centered care important?

The experience of the person interacting with our healthcare system can have a significant impact on the outcome of that interaction.

Impact of Person-Centered Care

- Improves clinical outcomes, the success rate of treatment procedures, including the need for follow-up care, and reduction in the length of average stays leading to substantial savings.
- Reduces healthcare expenditures, the number of productive hours per day by staff, staff levels, positive impact on staff retention, recruitment, and training.
- Creates competitive advantage, enhanced reputation in the community, continued patronization, the ability to attract new patients/residents, and parent/financial support.

Perceived Barriers to Person-Centered Care

- Providers
- Associations
- Reimbursement
- Workforce issues
- Policy-makers
- State Dept. of Health
- Authorities Having Jurisdiction
- Architects
Rothschild Regulatory Task Forces

Bring providers, designers, and the regulatory community together to recommend changes to existing national healthcare regulations which will enhance quality of life for health care communities across the continuum of care.

Rothschild Regulatory Task Forces

2008 Symposium on Culture Change and the Physical Environment Leads to National Long Term Care Life Safety Task Force
2011 Life Safety Code Changes

- Furniture may be provided in corridors if attached to wall or corridor
- Kitchens will be permitted to be open to other spaces and the corridor, subject to certain restrictions
- Kitchens may utilize a fire suppression system meeting requirements of UL 980A for residential range top cooking surfaces
- Any type of decorations will be permitted in resident rooms, corridors, on doors, in common areas and stairwells, subject to occupancy limitations
- Gas or electric fireplaces may be used in smoke compartments that contain sleeping rooms, but not within individual sleeping rooms

CMS Communication to State Survey Directors & State Fire Authorities

(March 3, 2012)

Rothschild Foundation

2015 Life Safety Code Task Force

National Trends in Delivery of Health and Long Term Care Services
March 19, 2015
Implications for Safety: Codes and Standards
LTC Trend Summary from NFPA Summit

- Residents want person-centered care, community, engagement, comfort, and information.
- Residents value personal healthcare delivery sites; they don't want to live in institutions; they want to age in place.
- Traditional healthcare settings, like nursing homes and hospitals, will face accommodations to a broader range of acuity levels and types of patients and residents.
- Financial pressures will continue to push care out of institutional settings into community and home.
- Technology will enable more care to be delivered in non-traditional settings.
- Community and home service health care delivery models designed for aging in place will continue to proliferate.
- There will be a growing demand for universal design home adaptations.

Dining Practice Standards: Endorsements

- American Association for Long-Term Care Nursing (AALTCN)
- American Association of Nurse Assessment Coordination (AANAC)
- American Dietetic Association (ADA)
- American Medical Directors Association (AMDA)
- American Occupational Therapy Association (AOTA)
- American Society of Consultant Pharmacists (ASCP)
- American Speech-Language-Hearing Association (ASHA)
- Dietary Managers Association (DMA)
- Geriatric Advanced Practice Nurses Association (GAPNA)
- Hartford Institute for Geriatric Nursing (HICN)
- National Association of Directors of Nursing Administration (NANDA)
- National Alliance for Long Term Care (NALTC/NAHCA)
- National Gerontological Nursing Association (NGNA)

Dining Clinical Standards: Areas of Practice

- Restricted Diet Liberalization
- Diabetes
- Low Salt Diet
- High Cholesterol Diet
- Altered Consistency Diet
- Tube Feeding
- Meal Food First
- Honoring Choices without Risk
- Informed Choice with Risk
- Shifting Traditional Professional Control to Support of Self-Directed Living
2014 Guidelines Revisions

Guidelines for Design and Construction of Health Care Facilities

Vol. 1: Hospital and Outpatient Facilities

Vol. 2: Residential Health, Care, and Support Facilities

- Person-centered terminology
- Examination rooms
- Battery operated vehicles
- Resident room performance criteria
- Outdoor areas
- Wellness centers
- Isolation rooms
- Householder assistance implications
- Specialty care populations

Americans with Disabilities Act (ADA)

ADA Accessibility Guidelines

New ADA Standards for Assisted Living & Nursing Home Residents
ADA Compliant Bathroom Design

2015 ICC/IBC Codes (I-Codes)

ICC/IBC Task Force to present changes consistent with Life Safety Recommendations.

January 3, 2012 deadline for code change proposals.
June 8, 2012 Posting of hearings.
August 1, 2012 Deadline for public comment.
October 24-28, 2012 Final action hearing.

ANSI/IESNA

A Vision for the Future

Developing recommended Practices for Lighting and the Visual Environment for Senior Living (ANSI/IESNA RP 26-07)

Meeting in May, 2012 at the U.S. Access Board to discuss implications and potential action steps to create a uniform set of guidelines for low vision.
Regulatory Challenges:

- We have a system of often overlapping and contradictory codes and standards.
- Many of today's codes were based on an institutional and/or acute model of care and are not person-centered.
- Navigating our regulatory system consumes large quantities of time and dollars better spent on health care programs and services.
- There are often immanent consequences to codes and standards which can negatively impact quality of life.
- Current codes and standards are based largely on historical concepts of facility-specific built environments.

Healthcare Interpretations Task Force

MISSION:
To provide consistent interpretations on national codes and standards referenced by CMS, JCAHO and state and territorial authorities having jurisdiction.
This will be accomplished through the evaluation of field conditions, surveys, inspectors and moral interpretations, and questions by consumers of those services generated through a member of the task force.
Correlation Committee
A Standing Committee of the HGRC

Members of this Committee identify elements of the document that have similar language or directly overlap (duplication) and determine which focus group has responsibility for the content.

The Correlation Committee is also responsible for proposing a way to eliminate conflicts and ensure requirements are consistent across the document. The Correlation Committee evaluates processes for distributing, discussing, and resolving issues identified as needing correlation.
ENCLOSURE C2
BRAINSTORMING DISCUSSION
JUNE 12, 2012

T. JAEGGER: Assisted Living Facilities (ALF) – Acuity going up, evacuation capability going down. Concern is that ALF’s will end up having to comply with nursing home regulation. Try to keep residential environment in place.

D. KLEIN: VA Foster Home program is expanding – up to 3 residents/patients in a home. VA has developed its own set of rules and safety guidelines for host families.

D. DAGENAIS: Home programs work because they don’t have a burdensome regulations structure. One concern is if a more formal regulatory system is put in place for home healthcare, then cost and enforcement of any such regulations might scare hosts families away and decrease the attractive nature of the at home healing environment.

V. HALL: Keep the family members together to the extent possible. One goal should be to minimize travel distance to visit or provide support. A lingering question is what does the at-home environment need? The companion model is to have the spouse (usually the wife) take care of the yet.

T. SCHIPPER: Anything must be information based – Building Information Modeling (BIM) is a tool that should or could be used more often when looking at design and performance issues in hospitals and nursing homes. Lean construction practices apply to reduce costs and improve completion time for projects. Commissioning Process – build in the best concepts, but keep pure. Reliability based inspection, testing and maintenance (ITM) programs – look for correlation between actual equipment performance and potential failure mechanisms.

R. STRUB: Codes don’t always align up perfectly; but CMS sometimes doesn’t have their reasons (policies) in line.

B. PREDIGER: DOD looking at Patient Centered Care programs. Part of this includes making renovations at various facilities to accommodate and offer the ability to provide all levels of services at one location.

T. SCHEIBEL: Need to look at the Continuum of Care – Home Health; Social Services; de-institutionalization; Group Homes; wrap around services; wrap around care. Need to look at, and across gaps – as some of those areas may not be regulated. No effort to “Coordinate the Continuum.” Developers and contractors shy away from Universal Design – “Because we don’t want it to look like old people live there.” - But they do.
B. BEREK: Need to look at how the ever expanding list of devices (Smart Phones; Tablets) and other technology can be used more effectively.

T. JAEGGER: Does “person centered care” encourage home health care? YES. But no life safety or NFPA 99 type regulations exist. It will be hard to tell if a life safety problem exists—until a spike in at home related injuries from fire or other emergencies arises until the number of at home patients increases substantially.

T. SCHEIBEL: At the 2010 NFPA/FPRF Healthcare Summit, the issue was raised to do guidance document to address the home healthcare issue; look at environment and risk for certain types of equipment that might introduce a fire or other safety hazard. There may be a tie in to Tele-Medicine to address some of the concern over equipment reliability.

R. MAYER: At what point does the acuity level change and you have to move a resident/patient to the next level of care? How much design flexibility can you put into a home for example that could accommodate an individual (with or without a care giver) over the longest time period?

P. LARRIMER: The VA guidance documents can be overwhelming to some of the potential VA foster home providers. A more generalized guidance document or recommended practice might be better suited to a layperson.

T. SCHEIBEL: Post Katrina – no guidance to facilities on managing local/regional emergency situations. Local communities need something to work with.

T. JAEGGER: Home Health Care issues are the classic hot potato – it could use some guidance but no one wants it.

C. STEPHEN: How can hospital and nursing home design get into a groove? What overlapping design items can be used in both environments?

J. WILLIAMS: Consider expanded use of performance based (PB) Design options. Design flexibility might create innovative solutions that aren’t currently permitted by the code.

R. SOLOMON: PB design option introduced to NFPA 101 in the 2000 edition few takers because: most building designs do not need the complexity that PBD options introduce; some concerns raised over the liability if something goes wrong. Medical community uses evidence based design (show me that it works and I will adopt that practice or technique).
**T. SCHIPPER:** Have heard some great ideas and suggestions, but this is a big task. How do you get this moving??

**B. BEREK:** Get the clinical folks involved and engaged in the design process—they ultimately have to use the facility.

**K. BUSH:** Where does the design community go?? They want and need to have the comfort level here.