Attendee Questions: This Session is a "Disaster"

Q: Will the recording be available afterwards?
A: All recent AAH webinars are available to stream on the AAH Vimeo channel. Learn about current issues affecting healthcare architectural practice on your own schedule: www.aia.org/aahwebinarvideos

Q: Will the slides be available afterwards?
A: You can download a PDF copy of the presentation at https://bit.ly/AAH2101

Q: While FGI may not have caught up with EDs in a flood level, generally building codes mandate that habitable spaces be built above at least the 100-year flood elevation as defined by FEMA. Wouldn't that suffice as FGI refers to related codes?
A: FGI works with other federal and private organizations to make sure we are not conflicting with their codes or standards. When it comes to floods and storm surges, we are looking to recommend that spaces such as switchgear, generators, ventilation systems, elevator controls, etc. are not located in an area that is vulnerable to flooding.

Q: Do you think you might change the 5'-6" requirements you just showed in certain areas of the proposed drafts to 6'-0"? per COVID-19 standards?
A: I don't believe you will see a change as this is the minimum size for the low-acuity pod. There still needs to be circulating space around the units so the space from patient to patient should exceed the 6'-0" being recommended for social distancing, but these ED patient care units are not only for use during an emergency condition; they will be included in the 2022 Hospital and Outpatient *Guidelines*.

Q: Are these Guideline available online?
A: Yes, there is an annual subscription for a digital offer. Our digital partner is MADCAD and the website address is: https://fgi.madcad.com

Q: At only 40 square feet, how is a "Low acuity pod" defined? Walls, physical partial height dividers, visual dividers, a curtain, a line on the floor...?
A: The models we are working off of always show a physical pod most of which are modular/prefab units. In the past eight years of working on this language, I have not seen one proposal that would permit the pod to be a chair with tape on the floor outlining the square footage. See the photo below for an example of how a low-acuity patient treatment station might be set up.

Q: With regards to handrails, if they are required on one side does that then preclude the ability to have doors on both sides of the corridor at the same location? Example would be a patient room entry across from a clean utility.
A: Handrails are required on both sides of a hospital patient corridor. Here is the proposed wording: "Where features preclude continuous handrails (e.g., nurse stations, doors, alcoves, fire extinguisher cabinets, etc.), handrails shall not be required. Where the distance between any two features is less than 24", handrails shall not be required within that opening."

Q: Be cautious how stringent you get with acoustic guidelines, just because you can 'hear' activity in the next room, does not mean you can understand what is being said. This needs to be balanced with cost to implement.
A: Agreed, we have a large task group looking into all the acoustic recommendations. The primary concern in a telemedicine room is that people passing by the room won't be able to hear the conversation taking place within the room. When people are conversing through digital platforms, there is often a need to speak louder to be heard clearly on the receiving end. The new requirements for telemedicine rooms are intended to address this.

Q: For elevator door width change to 48", would that impact the elevator size for gurney compliance?
A: The interior clearances for elevators servicing patient care areas has not changed, only the door opening clearance is being recommended for change.

Q: What does EVS stands for?
A: Environmental Services. This is a reference to having a "janitor's closet" on each patient unit.

Q: How does disinfection after use and possible fumigation requirements have an impact on finishes and materials?
A: It has a tremendous impact on many materials. FGI has not been conducting research but there are resources at https://www.healthcaresurfacesinstitute.org and the Center for Health Design's Knowledge Repository at https://www.healthdesign.org/knowledge-repository.

Q: For highly infectious diseases, an anteroom would be required for donning and another room for doffing to avoid cross contamination, the first one can be shared between rooms, is this also considered?
A: At this time and for the 2022 series of *Guidelines*, we have not focused on highly infectious disease units. There is a research project being conducted through a CDC grant. Therefore, we don't have any specific language recommended for sharing of anteroom space. The ECC white paper, however, does provide a recommendation to "consider compartmentalizing patient spaces and/or units to develop a self-contained airborne infection isolation unit." The matter of donning in one space and doffing in another has not been addressed.

Q: What is the impact on lab, should there be a BSL 3 unit within?
A: FGI is not looking at expanding beyond our current lab requirements. The pending white paper does propose an appendix item on emergency conditions planning considerations for alternate specimen collection sites, but that's the only change proposed for laboratories.

Q: Morgue and infectious cadavers, any recommendations?
A: The committee did recommend placing body-holding refrigerators on the essential electrical system, but there is nothing addressing infectious cadavers at this time.

Q: ASHRAE 170, and HEPA filtration to recirculating air, any recommendations?
A: There is a lot of discussion about going to 100% outside air, units with housings for adding HEPA filters when necessary. To date there are no hard recommendations as this topic is still being debated.

Q: Why wouldn't the FGI Guidelines address some lessons learned on Operational Considerations for Alternative Care and Modular Facilities. We have these lessons learned documented in other presentations.
how can handrails be continuous if patient room doors are directly across from each other,
A: FGI tries to focus on the physical environment and not get into the operational issues of health care organizations. We partner with AHA/ASHE and other membership organizations to handle the operational issues.

Q: You mentioned that exam room adaptability would be HIPPA based not space based. Please elaborate.
A: The recommendation from the Emergency Conditions Committee was that all exam rooms be "telemedicine-capable" and HIPAA compliant. The language that is proposed as an appendix in the EC *Guidelines* was modified to read: "Any space that is HIPAA-compliant is suitable as a telemedicine health care provider environment." This language is advisory only.

Q: Hospital requested a negative OR to treat COVID-19 patient. Any thoughts?
A: To date we are highly recommending ORs are not under negative pressure. The standards are looking to expand to include ORs that have negative pressure anterooms associated with each entrance and a positive pressure OR. No organization I know of is recommending ORs be converted or designed to negative pressure.

Q: Is it correct understanding these recommendations will eventually be put forth for incorporation into Uniform/Building Code?
A: Not to our understanding. The *Guidelines* are adopted by federal, state, and private organizations but have not been adopted by the ICC.

Q: Any guidance how we can design good acoustic when facilities are next to highway etc.
A: This is where getting an acoustic engineer involved in the design would be a good idea. There are building systems, walls, and windows that can assist in cutting down noise from the exterior.

Q: Is the increase from 80 to 100sf for HUMAN Decontam Room?
A: Yes, this is the small room associated with the ED for decontaminating one or two patients at a time.

Q: Is the Disaster White Paper intended to be adopted by an AHJ?
A: No, the white paper is intended as a best practice, case study, lessons learned, etc. That is why we are writing an Emergency Conditions Guidelines. The white paper will be over 500 pages and the new guideline may be 10 or less pages. The draft *Guidelines for Emergency Conditions in Health and Residential Care Facilities* will be included in the white paper. When the paper is released, the public is encouraged to comment on the draft Emergency Conditions *Guidelines* at emergencyconditions.fgiguidelines.net.

Q: When does the comment time start?
A: The comment period will start as soon as the white paper is released which should be in a few weeks.

Q: Where NO2 is used in labor delivery do I understand correctly that wagd is not required? or is required?
A: If nitrous oxide is used or other general anesthesia provided, NFPA 99 would require WAGD.

Q: Does the behavioral health crisis unit require daylight?
A: No, this unit could be an internal area within or near the ED. It will have observation beds, either single or multiple bed units. However, there is an appendix item in the 2022 draft *Guidelines* that recommends access to nature and daylighting.

Q: Are there any environmental requirements--triple glazed windows?
A: Not sure what this question is addressing, acoustics or resiliency?

Q: Curious why ED's aren't listed as being located above flood plain. Why?
A: Interesting that they are specifically mentioned. We currently have a section in the *Guidelines* on floods but don't call out specific areas needing to be above the 100-year flood plain. In the EC white paper, the spaces identified for removal above the flood plain are those where infection prevention and control measures would be severely compromised by a flood (e.g., sterile processing, blood bank, pharmacy).

Q: Is an "exit room" being considered as an alternative to anterooms. This allows unidirectional flow and does not disrupt normal operations.
A: Not in the language I have read in the white paper. It does raise an interesting concept, but I am wondering what difference there would be between an exit room and an anteroom?