Report on Draft Comments

Modifying the Draft Rules

Chapter 246-320 WAC

(Construction Standards only)

March 21, 2024

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Summary

This document serves as a compiled report of all discussions to change the initial draft of revisions to Chapter 246-320 Washington Administrative Code. The initial draft proposed to adopt the 2022 version of the Facility Guidelines Institute (FGI)'s Guidelines for Design and Construction of Hospitals and Guidelines for Design and Construction of Outpatient Facilities was published on October 31, 2023. This document includes both the proposals and comments to proposal received during the comment period, as well as general discussion heard during the second public meeting, as described below:

Public Workshop Meeting 2 – Review Comments on Draft Proposals

March 21, 2024
Start time: 9:00 a.m.
End time: 10:20 a.m.
Virtual meeting: Teams

Attendees:

Susan Upton, DOH Jason Suko, DOH Ann Cho-Hunt, DOH Elisabeth Riehl, DOH Megan Maxey, DOH	Desiree' Thom Amy McCargar-Davis, MultiCare Michael Brauhn, MultiCare Nicole Wenzel, MultiCare Teddi McGuire, Providence Lauren Trocano, EvergreenHealth Patrick O'Neil Adam Knoll Jody Carona, HFPD

Next Steps:

- DOH Internal Review (drafting rule language)
- **Public Workshop Meeting 3** Summer 2024 (Draft rule is the agenda)
    - DOH files proposed rule (CR102)
- **Public Comment Period and Hearing** – mid fall 2024
- Rule effective winter 2024

DOH Contacts:

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3 – Review of Comments

Proposal 001:

Submitter: Susan Upton
Hospital Book Section: 2.7- 1.1.1 Applicable Medical Units
Proposal: Revise text as follows:

2.7-1.1.1 Temporary basis

(1) This chapter shall be applied to mobile/transportable medical units that are used on a temporary basis.

(2) In the absence of state and local standards, "temporary basis" shall be defined as a period of time not exceeding six months during any 12-month period from the time procedures commence inside the mobile/transportable unit until the time procedures cease and the unit is transported off the host facility's site.

~~2.7-1.1.1.2.2 This chapter shall not be applied to modular/transportable units that will not remain on-site more than 96 hours.~~

2.7-1.1.1.~~3~~2 The requirements of this chapter shall not be applied to federally funded mobile/transportable medical units designed for and placed into service to respond to a civil or local emergency or catastrophe.

2.7-1.1.1.~~4~~ 3 This chapter shall not be applied to modular/relocatable units that are prefabricated off-site and finished on-site and transported to a permanent foundation.

Statement of Problem and Substantiation:

This proposal is to delete 2.7-1.1.1.2 that exempts mobile transportable medical units onsite less than 96 hours from the requirements of Chapter 2.7. The text was added during the 2022 revision cycle. The 96 hours requirement is arbitrary; time on-site should not be used to determine the quality of care provided. What evidence-based research determined that time limited on-site does not impact quality health care. These standards should be effective for all mobile units and not be subject to an arbitrary timeframe to prevent the use of essentially unregulated mobile medical units that could include mobile Cath labs and mobile surgical facilities. The original intent of this requirement was to make it easier for mobile units to provide services in rural locations not connected with any medical facility; this rule was never intended to apply to hospital licensed locations. The proposal would not impact mobile blood units, or primary care mobile units (such as mammograms) located in a parking lot; as the intent of this section is already covered in the WAC.

Cost Impacts: None as the 2014 edition of the Guidelines does not include this text; it was newly added to the 2022 edition.

Benefits: Patient safety

Discussion notes from the January 11, 2024 Workshop 1 meeting:
Question was asked whether this proposal would apply to emergency events such as the recent COVID 19 pandemic. DOH stated that the Governor has the authority to issue temporary proclamations (waivers of licensing rules) when deemed appropriate during emergency events.

Workshop 1 advisory opinion*:* Vote was taken to determine the attendees' recommendation to either support or reject this proposal; there were no objections, the proposal was supported.

Comments on Proposal 01: - None
Submitter: N/A
Section: Hospital Book 2.7- 1.1.1 Applicable Medical Units
Position: N/A

State of Problem and Substantiation for Comment: N/A
Cost Impacts: N/A

Workshop 2 advisory opinion: Vote was taken to determine the attendees' recommendation to either support or reject this proposal; there were no objections, the proposal was supported.

Proposal 002:

Submitter: Susan Upton
Outpatient Book Section: 2.13- 1.1.1 Applicable Medical Units
Proposal: Revise text as follows:

2.13-1.1.1 Temporary basis

(1) This chapter shall be applied to mobile/transportable medical units that are used on a temporary basis.

(2) In the absence of state and local standards, "temporary basis" shall be defined as a period of time not exceeding six months during any 12-month period from the time procedures commence inside the mobile/transportable unit until the time procedures cease and the unit is transported off the host facility's site.

~~2.13-1.1.1.2 This chapter shall not be applied to modular/transportable units that will not remain on-site more than 96 hours.~~

2.13-1.1.1.~~3~~2 The requirements of this chapter shall not be applied to federally funded mobile/transportable medical units designed for and placed into service to respond to a civil or local emergency or catastrophe.

2.13-1.1.1.~~4~~ 3 This chapter shall not be applied to modular/relocatable units that are prefabricated off-site and finished on-site and transported to a permanent foundation.

Statement of Problem and Substantiation:
This is identical to proposal 001, only difference is this applies to outpatient.

Cost Impacts: This is identical to proposal 001, only difference is this applies to outpatient.

Benefits: This is identical to proposal 001, only difference is this applies to outpatient.

Discussion notes from the January 11, 2024 Workshop 1 meeting:
No questions or objections were raised by the public on this proposal.

Workshop 1 advisory opinion: Vote was taken to determine the attendees' recommendation to either support or reject this proposal; there were no objections, the proposal was supported.

Comments on Proposal 02: - None
Submitter: N/A
Section: Outpatient Book 2.13- 1.1.1
Position: N/A
State of Problem and Substantiation for Comment: N/A
Cost Impacts: N/A

Workshop 2 advisory opinion: Vote was taken to determine the attendees' recommendation to either support or reject this proposal; there were no objections, the proposal was supported.

Proposal 003:

Submitter: Susan Upton
Hospital Book Section: 2.1-8.4.2.5
Proposal: Revise text as follows:

Heated potable water distribution systems
(1) Facilities shall develop a Water Management Plan that is risk based and includes provisions for controlling Legionella bacteria and other opportunistic waterborne pathogens.
~~(1)~~ (2) Provisions based on a risk management plan shall be included in the heated potable water system to limit the amount of Legionella bacteria and other opportunistic waterborne pathogens.

Statement of Problem and Substantiation: Clarify language needed to clearly state that a Facility Water Management Plan for Legionella Risk Management is a requirement; the existing language is tangentially based on reference to the appendix. This is required per CMS QS0-17-30 revised 07.06.2018 stating the Healthcare Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water.

There have been a number of incidents with waterborne pathogen outbreaks in Washington State Healthcare facilities and this requirement for facilities to develop and adhere to a Water Management Plan helps reduce the risk for Legionella and other pathogens in their water systems.

Appendix A2.1-8.4.2.5 Legionella Risk Management for Building Water Systems reference to CDC Guidelines for Environmental Infection Control in Health-Care Facilities, ANSI/ASHRAE Standard 188B: Legionellosis: and ASHRAE Guide 12: Minimizing the Risk of Legionellosis Associated with Building Water Systems.

Cost Impacts: None, CDC already requires hospitals to have a Water Management Plan.

Benefits: Clarified requirement; to ensure that design of hot water system has been integrated with the facility's WMP for continued operation and maintenance.

Discussion notes from the January 11, 2024 Workshop 1 meeting:
Question was asked if CRS would require a facility Water Management Plan (WMP) to be submitted for all CRS projects. DOH responded that only new hospitals or projects with major modifications to the domestic/potable water system would be required to submit a copy of the WMP, when requested by the CRS plan reviewer.

Workshop 1 advisory opinion*:* Vote was taken to determine the attendees' recommendation to either support or reject this proposal; there were no objections, the proposal was supported.

Comments on Proposal 03:
Submitter: Amy McCargar-Davis, MultiCare Health Systems
Section: Hospital Book Section: 2.1-8.4.2.5
Position: Expressing concerns only at this time

State of Problem and Substantiation for Comment: We have concerns around when, in the project life cycle, the water management plans would be required to be submitted to CRS. Often, at the start of the project, it is not possible to have all the location-specific documentation complete for operational go-live. These are developed as construction gets closer to the end and we have operational stakeholders onboard who will be working in the new space.

Cost Impacts: This change will increase construction costs. The cost would vary.

Benefits: It would be beneficial to ensure water management plans could be submitted as they are developed during the construction process.

Discussion notes from the March 21, 2024 Workshop 2 meeting:
Nicole of MultiCare Health Systems stated that she had no comments as they already do this (WMP) and that it would only be a cost increase if they are required to submit a water management plan every time. Susan of DOH noted that other than the pre-construction IRCA, DOH does not require facilities to submit for review all of the FGI required risk assessments and operational/management plans required by FGI 1.2. This proposal is intended to clarify that a WMP is required by CMS QS0-17-03. Only new hospitals, or projects with major modifications to the domestic/potable water system, would be required to submit a copy of the WMP, **when** requested by the CRS plan reviewer.

Workshop 2 advisory opinion: Vote was taken to determine the attendees' recommendation to either support or reject this proposal; there were no objections, the proposal was supported.

Proposal 004:

Submitter: Susan Upton
Hospital Book Section: 1.2-8 Commissioning
Proposal: Add new section as follows:

1.2-8.1 On projects involving installation of new or modification to existing physical environment elements critical to patient care and safety or facility energy use, at minimum the following systems shall be commissioned:
1.28.1.1 HVAC
1.2-8.12 Automatic temperature control
1.2-8.1.3 Domestic hot water
1.2-8.1.4 Fire alarm and fire protection systems (integration with other systems)
1.2-8.1.5 Essential electrical power systems
1.2-8.1.6 Security systems
1.2-8.1.7 Telecommunication systems
1.2-8.1.8 Wireless communication systems

Statement of Problem and Substantiation:
Telecommunication systems and wireless communication systems are fundamental systems for patient safety and should be commissioned to ensure reliability of system. Hospital requirements should not be less than the Outpatient requirements.

Cost Impacts: Minimal

Benefits: Improved patient safety

Discussion notes from the January 11, 2024 Workshop 1 meeting:
No questions or objections were raised by the public on this proposal.

Workshop 1 advisory opinion*:* Vote was taken to determine the attendees' recommendation to either support or reject this proposal; there were no objections, the proposal was supported.

Comments on Proposal 04:
Submitter: Amy McCargar-Davis, MultiCare Health Systems
Section: Hospital Book Section: 1.2-8.1
Position: Revise text as follow:
1.2-8.1 On projects involving installation of new or modification to existing physical environment elements critical to patient care and safety or facility energy use, at minimum the following systems shall be commissioned:
1.28.1.1 HVAC
1.2-8.12 Automatic temperature control

1.2-8.1.3 Domestic hot water
1.2-8.1.4 Fire alarm and fire protection systems (integration with other systems)
1.2-8.1.5 Essential electrical power systems
1.2-8.1.6 Security systems
~~1.2-8.1.7 Telecommunication systems~~
~~1.2-8.1.8 Wireless communication systems~~

State of Problem and Substantiation for Comment: Adding telecom and wireless systems to commissioning requirements will add costs to construction projects for all scopes of work done on telecom and wireless communication systems.

Cost Impacts: This change will increase construction cost. The cost will vary depending on the project.

Benefits: We are concerned with the amount of cost increase the inclusion of Telecommunication systems and Wireless communication systems to this section.

Discussion notes from the March 21, 2024 Workshop 2 meeting:
Nicole of MultiCare expressed concern that it will add cost to the organization if have to hire a third-party commissioning agent to test the telecommunication and wireless communication systems. Susan of DOH stated that the intent of the requirement is for testing and validation that the newly installed communication systems function as designed. Michael of MultiCare agreed that telecommunication and wireless systems testing should be validated prior to use before a building is turned over. Discussed the application of the term “commissioning” vs. “testing” to clarify when third-party commissioning would be required compared to testing performed by the system installer or the facility in-house person responsible for the system. Suggested to change language on 1.2-8.1 to commissioning and/or testing.

Workshop 2 advisory opinion: Vote was taken to determine the attendees’ recommendation to either support or reject this proposal with modified language to “commissioning and/or testing” and include telecommunication and wireless communication systems. Eight of nine attendees voted to accept the modified proposal.

Proposal 005:

Submitter: John Williams
Section: **ASHE 170 – Section 6.1.2.3**
Proposal: Add new section as follows:

6.1.2.3
Systems that provide heating whose source is dependent on variables outside of the facilities direct control shall provide a redundant heating source to provide the capability of maintaining the internal temperatures listed in Table 7-1. Examples of these types of systems include but are not limited to solar heating, heat pumps, geothermal heat, and variable refrigerant flow systems.

Exception: The facility or designer can demonstrate through independent engineering analysis and commissioning that the system is capable of maintaining facility temperature that support the facility operational plan. This includes continuity of operations, continuous operation of water-based systems and equipment, and patient care and comfort.

Statement of Problem and Substantiation:
Some of the new energy efficient HVAC systems are dependent on environmental factors – outside air temperature, sunlight, etc. The manufacturers of these system are developing more powerful and effective systems which may or may not meet the operational needs of a healthcare facility. The codes and standards have not adequately addressed these new systems and warrant some functional consideration. Since the effectiveness of these system depend on a factor that is out of the facility's control, we believe that some level of redundancy should be required to maintain reasonable operation.

This proposal provides that redundancy only for those facilities that choose to use these systems. It does not specific the method of redundancy (electric reheat, hydronic, etc.) it only requires that the redundant system maintains temps inside of the facility. An exception is allowed to pursue an alternate path, and it provides some validation that the system will perform.

This addresses a gap in the code, and will allow CRS to prevent design that puts facilities in jeopardy. This would apply to both Hospital and Outpatient Books which include ASHE 170.

Cost Impacts: We estimate approximately $6.50 per square foot cost increase to those facilities that choose these systems.

Benefits: Hospitals will be more resilient and maintain continuous operations longer.

Discussion notes from the January 11, 2024 Workshop 1 meeting:

Tobin Thompson, ZGF stated that he would abstain from making a recommendation to either support or reject this proposal until he seeks input from their mechanical engineer design partners related to the specific language of the proposal.

Workshop 1 advisory opinion: Vote was taken to determine the attendees' recommendation to either support or reject this proposal; other than Tobin's abstain vote there were no objections, the proposal was supported.

Comments on Proposal 05:
Submitter: Teddi McGuire, Providence
Section: Section: ASHRAE 170 - 6.1.2.3
Position: Expressing concerns only at this time

State of Problem and Substantiation for Comment: Providence has concerns with this proposal and agree with comments at the public workshop that mechanical engineers should be part of this conversation. Through other regulation, the state is currently pushing building owners to go one direction with energy projects and these new (and needed) technologies are costly. To then back track and require us to have redundant systems increases that cost, and negates the direction the state wants building owners to go in. We want to do the right thing for our energy footprint, but may not choose to go with certain projects because while we want to choose the Cadillac-version of the project, we may opt for something lower than that because we also have to budget for the backup.

Cost Impacts: Not provided.

Benefits: Not provided.

Discussion notes from the March 21, 2024 Workshop 2 meeting:
Patrick O'Neil agreed with the comment that facilities are being pushed in different directions if they are required to provide new types of systems to comply with the energy code while still maintaining older systems. Susan stated that the intent of this proposal is not to require both old and new technology heating systems; rather the intent of this proposal is to address a gap in the codes and standards which lag behind new equipment technology to ensure that the hospital heating source is reliable. This proposal provides that redundancy only for those facilities that choose to use systems that rely on environmental conditions outside the owner's control. It does not specify the method of redundancy (electric reheat, hydronic, etc.). This proposal includes an exception path based on a professional engineer BOD system analysis validating that the system will perform as designed.

Workshop 2 advisory opinion: Vote was taken to determine the attendees' recommendation to either support or reject this proposal; no objections given that the program understands attendees request to clarify the language to make it more clear that where an engineer analysis has been provided verifying reliability of heating system a redundant heating source is not required.

Proposal 006:

Submitter: Teddy McGuire
Section: **WAC 246-320-505(2)(1)**
Proposal: Add new section as follows:

(a) Preconstruction. Request and attend a presubmission conference for projects with a construction value of five hundred ~~two hundred fifty~~ thousand dollars or more. The presubmission conference shall be scheduled to occur for the review of construction documents that are no less than fifty percent complete.

Statement of Problem and Substantiation:
In today's market conditions, $250,000 is not a large project. Due to current difficulties with staffing and scheduling meetings with DOH, we are wondering whether this is an achievable target for DOH. This dollar amount could result in many projects requesting a meeting and any delays in scheduling and consequent approval from DOH which could lead to delays in the construction timeline and potential cost impacts.

$500,000 is better threshold for projects with potential complexity and would require an upfront discussion.

Cost Impacts:

Benefits:
Raising the threshold would not impact construction costs of a project. Delays in scheduling the review due to abundance of requests could potentially have an impact on costs.

Discussion notes from the January 11, 2024 Workshop 1 meeting:
No questions or objections were raised by the public on this proposal.

Workshop 1 advisory opinion: Vote was taken to determine the attendees' recommendation to either support or reject this proposal; there were no objections, the proposal was supported.

Comments on Proposal 06:
Submitter: Amy McCargar-Davis, MultiCare Health Systems
Section: WAC 246-320-505(2)(1)
Position: We support this proposal

State of Problem and Substantiation for Comment: We support this proposal.

Cost Impacts: This change will not increase construction costs. Operating cost impacts: n/a

Benefits: Adopting this proposal could decrease the number of projects that need to be taken through a pre-submission conference.

Discussion notes from the March 21, 2024 Workshop 2 meeting: N/A

Workshop 2 advisory opinion: Vote was taken to determine the attendees' recommendation to either support or reject this proposal; there were no objections, the proposal was supported.

Proposal 007:

Submitter: Lara Macklin
Hospital Book Section: 2.1-7.2.3.2
Proposal: Revise text as follows:

2.1-7.2.3.2 Walls and wall protection

(1) Wall finishes

(d) Wall finishes shall be impact resistant when there is potential for equipment or furniture to cause damage over time

(i) corridors

(ii) exam rooms

(iii) patient rooms in family area

(iv) team rooms

(v) waiting rooms

(vi) public bathrooms

Statement of Problem and Substantiation:
Too often the finishes are not fully thought out due to first time costs and budget constraints. Many times this only leads to more maintenance as soon as 6 months after the project is completed. The addition of wall protection in corridors, anywhere equipment/carts are staged, and even some public areas like bathrooms, can make long term maintenance easier.

Cost Impacts: Depends on the amount and size of the project

Benefits: The potential benefit that this allows is significant long term cost savings, FTE needs for repairs

Discussion notes from the January 11, 2024 Workshop 1 meeting:
Several attendees expressed concern about the added cost of this proposal, especially cost impacts to rural hospitals operating on very limited resources. It was suggested that the proposal language be modified during the comment period to have the facility conduct a risk assessment to determine areas where impact resistant wall protection is required. Another suggestion was to move this proposal language from the main text to the appendix.

Workshop 1 advisory opinion*:* Vote was taken to determine the attendees' recommendation to either support or reject this proposal; there were five objections to the proposal.

Comments on Proposal 07:

Submitter: Amy McCargar-Davis, MultiCare Health Systems
Section: Hospital Book Section: 2.1-7.2.3.2
Position: Revised test as follows:

Appendix ~~2.1-7.2.3.2~~ Walls and wall protection

(1) Wall finishes

(d) Wall finishes shall be impact resistant when there is potential for equipment or furniture to cause damage over time

(i) corridors

(ii) exam rooms

(iii) patient rooms in family area

(iv) team rooms

(v) waiting rooms

(vi) public bathrooms

State of Problem and Substantiation for Comment: We propose to remove this proposal entirely or to move this section to the Appendix so the proposal will be a recommendation, not a requirement. The proposal as it stands would add significant costs to projects. The proposed criteria appears to include protection for most walls in healthcare construction projects.

Cost Impacts: This change will increase construction costs. The cost impact per square foot would vary depending on the project. Operating cost impact would vary depending on the project.

Benefit: Removing this proposal would allow hospitals to determine the need for wall protection specific to each project and allow hospitals to control costs.

Discussion notes from the March 21, 2024 Workshop 2 meeting:
Michael Brauhn of MultiCare stated that moving to appendix, needs change at (1)(d) from "shall" to "should".

Workshop 2 advisory opinion: Vote was taken to determine the attendees' recommendation to either support or reject this proposal; there were no objections, the proposal was supported with a revision to move to the appendix and change from shall to should at (1)(d).

Proposal 008:

Submitter: Lara Macklin
Hospital Book Section: 1.2-4.1.2
Proposal: Add text and appendix as follows:

1.2-4.1.2.9 Storage

A1.2-4.1.5.2 Evaluation of underlying conditions that can cause adverse safety events
Space required to accommodate functions including storage space

Statement of Problem and Substantiation:
The current text is focused more on clinical safety, but this safety is based on the need to support the clinical teams. Too often the minimum requirements for all kinds of storage are not taken into account for assembling large support projects like IV pole or new Omnicell units, when sometimes hundreds arrive at one time. Space like this is next to impossible to find fast and for long periods of time. If space were identified as a multi-use area that could accommodate these needs and be flexible for other needs that would at least help the conversation.

Cost Impacts: It could be thousands or tens of thousands and up.

Benefits: The benefit is that it will allow space to be readily available in a short amount of time for when unexpected needs arise. Saving time and money.

Discussion notes from the January 11, 2024 Workshop 1 meeting:
Several attendees expressed opposition to this proposal. CRS noted that the proposed language is appendix language, which is recommendation, not a requirement.

Workshop 1 advisory opinion: Vote was taken to determine the attendees' recommendation; there were four objections to the proposal.

Comments on Proposal 08: - None
Submitter: N/A
Section: Hospital Book 1.2-4.1.2
Position: N/A

State of Problem and Substantiation for Comment: N/A
Cost Impacts: N/A

Discussion notes from the March 21, 2024 Workshop 2 meeting:

Workshop 2 advisory opinion: Vote was taken to determine the attendees' recommendation to either support or reject this proposal; eight of nine voted to reject proposed.

End of proposals