Facility Guidelines Institute
Residential Document Group Meeting Minutes
May 13-14, 2015
St. Louis, MO

Attendees: Jane Rohde, John Shoesmith, Addie Abushousheh, Asha Hegde, Ashley Blankenship, Bart Miller, Glenn Gall, Charlie Schlegel, Chris Mason, Doug Erickson, Chris Erickson, Eric Rosenbaum, Howie Groff, Jim Scott, Jim Faulkner, Jerry Smith, Larry Beresford, Leisa Hardage, Mandy Kachur, Michael White, Pamela Blumgart, Phillip Thomas, Robert Mayer, and Steve Lindsey. Gaius Nelson joined the meeting later in the morning.

Absent: Jude Rabig, Debra Harris, Frank Pitts, Skip Gregory, Steven Friedman, Steven Heaney, Tom Mullinax

The following was discussed and summarized for the first meeting of the Residential Document Group on May 13-14, 2015 in St. Louis.

I. Jane called meeting to order and went over room logistics.
II. Doug Erickson from Facility Guidelines Institute and the chair of the Health Guidelines Revision Committee provided introduction and welcome to the group. Items to note for overall 2018 Guidelines updates:
    a. Reduce number of cross-references in multiple sections as much as possible to allow code and regulations to be easily and effectively utilized.
    b. The Guidelines do not become a regulatory document until formally adopted by a governing body (i.e. state, health department, etc.).
    c. The Guidelines are intended to be minimum requirements and provide a baseline for design and construction recommendations for health care.
    d. Shared quote: “Can’t do the same thing over and over again without expecting the same results”
        – Einstein
    e. For the 2018 cycle, the Residential book will be considered the “fundamentals”; however a secondary document shall be completed that addresses “beyond fundamentals” information; such as practical examples, case studies, explanatory information, diagrams, etc.
        i. Questions/responses regarding the “fundamentals” versus “beyond fundamentals” information:
            1. Glen: “What are the fundamentals looking to be; will this be the Appendix that is currently in the existing guidelines?”
                a. No, the Appendix material will remain in the same document.
            2. The goal is for the “beyond fundamentals” to be a dynamic document that can also include floating new ideas or concepts for feedback and

evaluation; prior to being incorporated into the new fundamentals material.

3. Rob: Where do we stand with respect to adoption of the 2014 Guidelines? As you do that, it there any feedback by way of resistance or questions / barriers that would inform us moving forward?
    a. NJ and DE have adopted the 2014 Guidelines. IA, PA and MI are interested at this point. Need to have a marketing/educational program roll-out to address adoption by each state.
    b. Recommended pulling together a marketing committee or a small group that can provide feedback. AHJ's input is important in being successful for adoption; from Charlie, Jim, and other AHJs.
    c. 1900 copies sold since July, 2014.
4. Cost Benefit Matrix from 2014 cycle was included in materials. Leisa: does the cost benefit matrix illustrate information that we should consider?
    a. Matrix is a comparison of 2010-2014 information that Tom Jung and Pamela Ward assembled. Jane has taken information from that matrix and pulled out items that she felt should be addressed when looking at the 2108 residential guidelines and appropriate proposals.
    b. From a criteria perspective, Rob sent information to Doug on person-centered care – wanting to include this as part of the cost/benefit matrix. Doug is working with Tom Gormely to include as part of the criteria for evaluation.
    c. This document has been culled down to approximately 40 items for review and for proposal development for 2018.
    d. Proposal process information and inclusion of evidence support and cost benefit information will be part of the proposal submission process.
    e. Discussed the balance of person-centered care benefit; using lighting as an example. How do we meet power density requirements while giving appropriate lighting? This examples was addressed in 90.1 current version; however benefits are broader than $$, alone, when evaluating ROI and resident outcomes.

Introductions

I. Introductions were made for all attendees, along with a 'fun fact' about each person.

Agenda Review

I. Overview of Residential Document Group logistics, respond to questions related to procedure, process, etc. The following informational webinars for information were assigned prior to attending the meeting. For those who have not reviewed this information, recommend doing so in preparing information for proposals.

a. **HGRC Orientation Webinar 1: Introduction**
    i. https://join.onstreammedia.com/play/67347259/3927-hgrc-orientation-webinar-1
b. **HGRC Orientation Webinar 2: HGRC Activities**
    i. https://join.onstreammedia.com/play/67347259/4061-hgrc-orientation-webinar-2
c. **HGRC Orientation Webinar 3: Proposal Writing**
    i. https://join.onstreammedia.com/play/67347259/4077-hgrc-orientation-webinar-3

II. For the Residential Guidelines, 2014 is considered the Fundamental Baseline.
    a. For the Hospital and Outpatient books, a matrix is being utilized based upon research to determine the Fundamental Baseline.
    b. Appendix will still be part of the Fundamental Guidelines.

III. Have discussed with Addie an evaluation of research based information within the existing Residential Guidelines.
    a. Discussed how to approach the review of the document in a systematic manner for evaluation.
    b. Best practices and recommendations from research are important to support items that we might want to move or place in the main body of text. As you are looking for research to support your position, look for research that both supports and contrasts your position so that you can give full view of issue.
    c. Addie provided two resources that are easy to access and understand:
        i. Design for Dementia Info (http://www4.uwm.edu/dementiadesigninfo/)
        ii. Center for Health Design's Viewpoint Summaries (https://www.healthdesign.org/search/articles/viewpoint%20summarizes)
    d. Also, another resource includes peer reviewed articles, because they often have point counterpoint discussions and bibliographies that can be mined for information. Use key article as your reference. Note that providing the most succinct resource (versus multiple resources) that clearly supports the proposal being made are the most effective. This assists the voting members of the Residential Document Group to work through proposals in an efficient manner during the voting process at the Health Guidelines Revision Committee all-hands meeting.

IV. Parking Lot Items for consideration for beyond Fundamentals.
    a. Reminded the group to place items for future consideration or inclusion within the beyond fundamentals category for evaluation within the companion document.

V. Discussion
    a. Do you have to have evidence to put proposal forward? No, as the proposal should be based upon a best practice that has changed over time (example lighting) demonstrating a need for an update; or based upon changes or outdated information in the overall or specific facility type market place of senior living and long term care.
        i. Goal is not to limit the guidelines requirements, because there has not been research. If the Residential Document Group is in agreement that an item should be put forward, then this should be proposed upon, discussed, and evaluation.
        ii. Cost/benefit matrix tool is another evaluation tool for inclusion that can be referenced as support to a proposal a well.

Review of general items that impact the overall 2018 version of the Residential Guidelines

I. Current format and layout: discuss the following specific items:

a. Part 1: Risk Assessment: Evaluation of ECRI checklist from NASRM. The ECRI checklist was provided as part of the meeting preparation package. These items will be posted on Box.com with other Residential Document Group information and documents.
b. Discussion on risk versus safety. Look at how we are excessively disabling people by making places too safe for them and the need for balancing some risk with safety to support person-centered activities and environments.
    i. Example: I am admitted to LTC on Friday. Because I am a new admission they don't know if I am a falls risk. PT isn't in the facility until Monday; so in the meantime, I've lost 30% of mobility/capacity for movement in waiting to be assessed and therapy to occur. Likely labeled a falls risk on Monday because of the delay in review, so I am listed as non-ambulatory. Therefore, incontinence is now an issue – and so goes the spiral downward – based upon verifying the person is more 'safe' is actually disabling them.
    ii. There is a human factor that we cannot regulate in regard to risk versus safety, but we can reference other groups that have best practices that exist for specific issues. ECRI checklist would be an example and has been provided to the Group evaluating the Resident Safety Risk Assessment.
c. Design is driven by operations – i.e. functional program – and so some of the additional information could go into the beyond fundamentals companion publication that provides examples and results of actions to better understand the design impacts on operations and vice versa. In the example above, if there were better orders about the admissions of the person, therapy and evaluation was completed immediately, the disabling issue might not occur.
d. It was felt that case studies and/or scenarios within the beyond fundamentals companion document may be helpful - even if the beyond fundamental document is not specifically referenced from the fundamental document. By not referencing the document, it allows for supportive information to be provided that can be more dynamic, updated and more fluid than the four year cycle for the actual fundament Guidelines document.
e. Part 2: Common Elements and elimination of the second set of Common Elements in Part 3, 4, and 5.
    i. Reason: clarity of document and concise facility chapters / minimize cross-referencing. This was discussed, and format-wise thought this would be a better solution, even if it resulted in some duplicated information within the facility chapters themselves. This would allow all cross references to simply go back to the Part 2 Common Elements section.
    ii. Group agreed that having Common Elements only in Part 2 would be appropriate.
    iii. Impacts to the existing 2014 Guidelines (not including any new facility chapters that may be developed):
        1. Part 3: Residential Health Facilities would only include Nursing Homes and Hospice chapters.
        2. Part 4: Residential Care and Support Facilities would only include Assisted Living and Independent Living chapters.
        3. Part 5: Non-residential Care and Support Facilities, would only include Adult Day Care, Wellness Centers, and Outpatient Rehabilitation.

iv. For hospital and outpatient book, a similar format could be considered; being that there will be two new books for HOP settings.
v. Discussed the Memory Care overlay that is located in Part 2. Discussed adding information in the Appendix of facility chapters or reference with more description within the Facility Chapters.

f. Part 2: Sustainability Section as overlay. Discuss if elements of sustainability should be layered into sections of the Guidelines; I.E. Energy into Building Systems criteria, etc. or should this remain a separate overlay. Proposed definition as requested from the Steering Committee and informed by ASHE's definition: "Healthcare sustainability is a goal to reduce waste, conserve energy and water, and provide a healthier and safe environment for staff, residents and patients and their families."
    i. Goal is not to reiterate base code; i.e. IECC and IgCC as references with ASHRAE 189.1 and 189.3 standard content ultimately migrating into the IgCC.
    ii. Provide information that doesn't force providers to make poor decisions or costly decisions that are not sustainable over time.
    iii. Providing as an overlay is okay, but if information could be included within specific section may be more usable.
    iv. Discussion of ASHE Commissioning c requirement. (Commissioning Requirements for Residential Book. Will need to evaluate for 2018 cycle: reference the ASHE Commissioning (Cx) document. Reference as an option due to the cost impacts. Currently required.)
        1. Group agreed that this item should be in the Appendix instead of in the main body text.
        2. Jane to discuss with Doug about making this an errata or it needs to be accomplished in a different way.
    v. Evaluation with Building Systems group in relation to sustainable items on Energy, Water, and Indoor Environmental Quality and current overlay for recommendations for incorporation into the Part 2 Common Elements and Facility Chapters.
    vi. Resilience as a topic for long term care. This has been an issue from GSA perspective, as well as research framework being developed by NIST. (Climate change /adaptation plans). Healthcare delivery systems: HHS has created a guide for healthcare projects for consideration. See attached document as it was prepared in response to the "President's Climate Action Plan." It's also on the website http://toolkit.climate.gov/image/662. See also FACT SHEET: Strengthening the Climate Resilience of the Health Care Sector: https://www.whitehouse.gov/administration/eop/ceq/Press_Releases/December_15_2014.
        1. Resilience has been brought up through Katrina, Sandy and other disasters. When looking at risk assessments we should also look at resilience. Being that this information is being reviewed by GSA and government agencies, recommend evaluating in relationship with the Guidelines. FEMA has a regional guide.
        2. Resilience has to do with disaster preparedness, which is currently addressed in the Resident Safety Risk Assessment. Resilience also looks at the carbon footprint, as part of sustainability. GSA has a task force that is evaluating Resilience, Sustainability, and Facility Utilization.

a. Project Example: Katrina – Mississippi: Military Veterans Home rebuilt so that parking garage and elevator shaft can flood without impacting safety of those living there, because generator is located in a safe, non-impacted locations.

3. Discussed completing a white paper or a listing of resources in relationship to resilience to be posted on the FGI Website.
4. Discussed evaluating the disaster preparedness section of the risk assessment and broaden information and resources in the Appendix.
5. Discussed taking this information to the Emergency Preparedness Topic Group for consideration.
    a. CMS also has a Hazard Plan requirement.

vii. Should Population Health be part of the sustainability discussion? If yes, what should be included?

1. Discussed home health and public health (visiting nurses and other care in the home).
2. American Public Health Association is the organization that works on initiatives related to public health issues.
3. Evaluate as a filter as the document group continues work in the sustainability sector.
4. Discuss with sustainability topic group.
5. Population health approach to educate and support seniors, providers, families and others to provide care within a radius of the care community.

II. New Facility Types discussion:

a. Post-acute care: separate Facility Type or subset of Nursing Homes?

i. 3.2-1.1.2.1 Subacute care: See Section 3.2-2.2.4.1 (Subacute care facilities) for requirements currently in the 2014 Guidelines.

ii. Evaluation of post-acute care versus palliative care for chronic care management (versus terminal diagnosis) What would be differences that could be covered in the Guidelines that relate to completion of restorative care versus rehabilitation?

iii. Discussed the need to be mindful of cost impacts within post-acute care settings; to meet needs from earlier hospital discharges, but not to create too stringent of minimum guidelines and requirements, unless a much higher level of acuity of resident is being cared for.

iv. Group preferred post-acute care to be a subset of the nursing home guidelines, because all nursing home settings won't necessarily be providing post-acute rehabilitation or addressing a higher acuity level.

1. Discussed making this an overlay; similar to dementia care. Define post-acute care and "circle" back to evaluate the functional programming process to include evaluation.
2. Determine what considerations to include for post-acute care section.
3. Often post-acute is based upon a la carte services based upon an individual care plan.
4. Could provide language that states, if higher level of care is being provided, the following requirements shall be met. (Similar to how the evaluation of ventilators was handled. Discuss the options of what services could be included within a post-acute setting.

5. Discussed making the setting flexible and person-centered versus more restrictive environment.
6. There is a need for more care in AL as well; however viewed as more of a service delivery issue than an environmental one.

b. Palliative Care: should this be a separate Facility Type or subset of Hospice? Management of chronic diseases versus terminal illness.
    i. In consulting the hospice experts within the Document Committee; there are not very many separate 'facilities', but evaluated more as an overlay to Hospice.
    ii. Palliative care units are 'popping up' in hospitals and in some ways are in competition with hospice.
    iii. Discussed with the group to incorporate within the hospice chapter to address Palliative Care.
    iv. It was discussed that hospice design is predominantly focused on the family in regard to interaction with the overall space and environment; whereas palliative care design focuses on the resident and how they can be benefited by the environment. Palliative being focused on maximizing activity while managing multiple chronic diseases that cannot be handled or easily managed outside of a facility setting.
    v. Coordination with the Hospital Document Group to provide Guidelines that would support the inclusion of hospice and palliative care within the hospital setting.
c. Patient-centered Medical Home Model: should we provide information to the Outpatient Document Group, because of older adults being the primary user? There could be a 'diagnostics' section added to Part 5: Non-residential facility chapter.
    i. Should we add Treatment and Diagnostics section in the Non-Residential section? If yes, what would want to be included within the section?
    ii. Discussed addressing in each book as appropriate. Even though the main care population is 65 and over, the model is not intended only for seniors, but also for family and community at-large (including education, support, and outreach).
    iii. Health, wellness and preventative care guidance for campuses tht will integrate these types of services as place-types.
d. Small residential homes for those with intellectual disabilities: where should this be included? This was suggested by Frank Pitts for inclusion within Nursing Homes and potentially included within Assisted Living.
    i. Small residential homes for those with intellectual disabilities is a facility type certified by CMS.
    ii. Particularly if marketing to CMS, the residential guidelines would want to include guidelines on Intermediate Care Facilities (ICF)/Intellectual Disabilities (ID) homes.
    iii. Discussed making this section its own building type.
    iv. Consider adult family homes, as part of the evaluation.
    v. Impacts some assisted living settings, group homes for IL, and nursing home settings for higher level of care residents.
e. Part 1: Functional Programming: Continuous Improvement: Post Occupancy Evaluation
    i. Should we assemble a white paper on continuous improvement?
    ii. What is the process and how is evaluation completed for both improvement of care as well as improvement in the environment - touches on benchmarking, could be extended as part of the functional programming process, etc.

iii. Requested Addie to evaluate what guidelines are already available to discuss continuous improvement. White paper could outline resources available for continual improvement evaluation / benchmarking. Providers are collecting some environmental data as a by-product of other information that is being gathered. NCAL trend tracker is an example of an informational tool that is available. This may be an appropriate topic for beyond fundamentals.

f. White Paper: Because of all the changes with the Affordable Care Act. Discuss the need for addressing care transitions and how those are handled based upon the care environment and locations where care is occurring. (I.E. In relationship to the accountable care organizations and other reimbursement drivers.)
   i. Thought to be more operational and reimbursement based versus environmentally based.
   ii. Discussed care transitions; but other than flexibility, the care transition is a resident/patient/staff operational process. Anything that the environment can do to support communication and participation in making healthy care transitions is important.

III. Renovation versus New Construction: discussed the following:
   a. Do we want to evaluate additional information that would assist facilities to improve existing settings within tight constraints?
   b. Existing building stock is very large, and with more community based services, how should renovation be handled within the Guidelines?
   c. How would expanding amenities impact the design guidelines for existing settings?
      i. Evaluation of 2010: Example of compliance for Virginia for an addition/renovation in relationship to accessibility and adaptation.
         1. Have we made some of the requirements too difficult to comply with?
            a. Guidelines do include language: 1.4-3.5 Nonconforming Conditions.
         2. What are others experience to date in utilizing 2010 or 2014 Guidelines?
            a. Evaluate renovation more closely to allow renovations that approve alternative access to ADA requirements within resident rooms: to encourage design changes in existing facilities.
         3. Discussed working with ANSI/IBC as an approach for the grab bar issue discussion.
            a. New IBC is referencing the ANSI standard, which has made renovation and workable solutions for older adults more difficult.
         4. PA has variances that allow for different approaches based upon existing constraints. PA has also allowed variances to utilize fold-down grab bars.
            a. This may provide a template to refer to as a precedent. Involvement on the ANSI committee to be further discussed with Rothschild and FGI, in looking at a regulatory barrier to resident-centered design.
         5. Discussed utilizing case studies (beyond fundamentals) that may be able to support creative solutions for existing building conditions.

IV. Glossary Evaluation being completed by Addie.
   a. Addie has compiled glossary terms so that the Guidelines can match some of the glossary terminology of NFPA and other organizations. Addie is editing these definitions so that we and other groups can use them as common terms.

V. Topic Groups
    a. Geriatrics: evaluation of older adults and the design criteria related to utilizing Hospitals and Outpatient Settings. Discussed that “geriatrics” is not the correct terminology regarding safety and features that would support a Universal Design approach to healthcare settings. Changed to “Health, Wellness & Preventative Care” as the title for the Topic Group Section.
        i. Information will be generated and shared back with the Hospital and Outpatient Document Groups for consideration within their books.
            1. Will need evidence support and examples.
            2. Review entry sequence and operational processes involving older patients.
            3. How would this impact older staff?
        ii. Is there anything that we would want to include about geriatrics or gerontology within the Residential Guidelines?
            1. References?
            2. Research?
        iii. Should we develop a white paper regarding geriatrics?
        iv. Discussed developing white papers on this topic.
        v. Goal to infuse common environmental strategies that can benefit the hospital and sub-acute settings; such as (day) lighting, acoustics/glare, way-finding in acute care. Basic understanding of the aging process from a bio-psycho-social perspective. Identify seminal articles that could be disseminated.
        vi. Go to www.box.com for the “Health, Wellness & Preventative Care” Notes from the workgroup breakout for additional information.
    b. Bariatrics: evaluation of overlay section for improvements (discussed with Debra Harris for support based upon her research background). Bariatric topic is tied to functional program. There are currently no mandated percentages of rooms. Sizes and some clearances are covered within the Guideline overlay in Part 2: Common Elements.
        i. Cannot design facilities that meet the needs of bariatric across the board. It’s not just the patient, it’s their families as well.
        ii. The bathrooms, rails, equipment, beds, clearances, etc. essentially knock the renovation option out of the running, or make it extremely difficult at best.
    c. Technology
        i. Errata regarding Nurse Call and UL changes for Assisted Living.
        ii. What else needs to be considered and addressed within technology?
        iii. Building systems includes majority of technology information. Should this be broken out into a separate section?
        iv. Visual and hearing impairments versus age in evaluating guidelines. What should be included?
            1. Improvements could be improved for everyone through technology and finishes. Discussed, could we deal with the biopsychosocial aspects of aging?
        v. Recommend Gloria Cascarino from The Center: Environmental Standards Council to the Topic Group.
        vi. Areas for evaluation:
            1. Chris Mason discussed the need for integration of systems:
                a. Emergency systems – call, wandering, fire, etc.

b. Point of sale, network, stations, clinic, wellness
c. In-room entertainment systems integration / telephone
d. Marketing
e. Keyless entry systems
f. Specialty spaces – Doc in a box

2. Coordination of care discussed. For example technology allows for dialysis to be completed at home or brought to the resident. This type of discussion could be evaluated through the Health, Wellness, and Preventative Care section – and addresses the continuum of care as an example.
3. John Shoesmith discussed silent fire alarms with pagers in AL settings. You can have private signaling in I2 settings. The pagers don't communicate with the fire alarm systems in a way that is UL approved. The strobes are another issue that need to be addressed. We can address the performance characteristics. This might be a topic for a white paper or the "beyond fundamentals" book.
4. Discussed surveillance from a safety perspective vs. privacy with nanny cams. Desire to maintain a safe environment, but with privacy considerations.

VI. Task Groups

a. Acoustics: update on the Task Group and research project provided by Mandy.
    i. Hearing impairment considerations should be tied to acoustics work group.
    ii. Mandy reported that acoustic task group is completing on-site research outside of Boston at Brooksby Village - a CCRC. On-site evaluation includes taking measurements of speech privacy, intelligibility, sound levels in a variety of spaces, etc.
    iii. Areas of complaint include dining room, mechanical equipment, elevators, traffic noise, and lawn maintenance equipment.
    iv. Addie outlined her observations from staying in long term care settings. She will share observations and list with Mandy. Issues contribute to sleep disruption and issues of understanding the noise by people with cognitive issues.
b. Evaluation of including furniture in calculations.
c. Shared example of Resident Room with hard surface ceilings, walls, and floors provided by Skip Gregory in establishing requirements utilizing 2010 Guidelines in the State of Florida and the difficulties of compliance.
d. Reviewed the status and update on Low Vision Task Group, IES: RP-28-2015, and ASHRAE 90.1 2013 (power density).
    i. Now that the Low Vision Guidelines are completed, evaluate and reference them within the Guidelines. Determine if these are directly referenced within the Guideline or considered a 'beyond fundamental' document resource.
    ii. Low Vision task group finished voting on the 2015 RP-28 and it has passed. Likely will be 90 days until published. Illuminance levels listed in RP-28 chart and Low Vision Chart on surfaces and materials will be very useful. RP-28 focused on visual aspect and safety issues. There is a focus on health issues (circadian rhythms, etc.); therefore committee is evaluating lighting from a holistic perspective.

1. The low-vision document has just gone through a voting process. There are low-vision and aging sections. They are complimentary in addressing surfaces, materials, and health outcomes.

iii. Discussed the process that would be required to update the RP-28 to the current version for the 2014 Guidelines. Current version is 2007 and new edition is 2015.

e. ADA/Federal Access Board & DFA task group on adjusting ADA for older adults.
   i. See notes above regarding the discussion of addressing the ANSI reference in the IBC.

VII. **Break Out Groups**: Group Assignment also included in attached Roster Excel Spreadsheet File for reference.

a. **Group 1: Part 1: Risk Assessment Review & EOC**: **4 people: Jerry, Pamela (Scribe: Bring Laptop), Rob, Steve L.**
   i. Evaluate ECRI document against the Risk Assessment language in the document to create recommended language changes.
   ii. Review current language in Risk Assessment compared to final language for HOP book.
   iii. Review of EOC; including daylighting, views, and access to outdoor therapeutic environments.
   iv. Discussed completing a white paper on safety versus risk discussion per Addie.
      1. Discussed examples of mitigation of risk provided negative resident outcomes.
      2. Discussed then need for a balance between safety and risk with quality of life.
      3. Evaluate tying this information into the functional program process.
   v. Pamela to post Group 1 documentation on Box.com.

b. **Group 2: Nursing Home: 3 people: Jane (Scribe: Bring Laptop), Jude, Charlie (Frank as required)**
   i. How many residents, to be able to combine soiled utility and environmental services spaces? (3.1)
   ii. Pioneer Network discussion follow-up:
      1. Can soiled utility rooms have more flexible requirements? Group 2 evaluated the soiled utility spaces within break out session. Documentation posted on Box.com.
   iii. Evaluate language for Post Acute Care based upon earlier discussion.
      1. Discussed assembling language from other sections to develop additional information for Post Acute Care. This could be additional information within the Residential Health section, specifically within Nursing Home: as long term care setting for rehabilitation within a skilled setting.
      2. Discussed evaluating the distinguishing physical environmental features that make this a different type of setting from Long Term Care, Hospice, and Palliative Care.
      3. Wanting to turn the building into an advocate versus the enemy (Howie Groff).

iv. Evaluate inclusion of smaller scaled settings for Developmentally Disabled. Discussed and agreed that a separate facility type chapter in Part 4 would be appropriate for TBI, DD, mental health, etc.
    1. For the Nursing Home facility chapter, evaluate for long term residents that need full care, if there is additional information that needs to be added.

c. **Group 3: Hospice: 3 people: Jim and Larry (to follow-up with Tom Mullinax)**
    i. Evaluate language for Palliative Care based upon earlier discussion.
    ii. Should there be an overlay for the Hospital book for in-patient hospice within hospital facilities?
        1. Hospice designs are primarily focused on supporting grieving families versus palliative care design are primarily focused on the resident/client.
    iii. Evaluate existing language for updates based upon changes in the marketplace.
    iv. Group started to redefine and contextualize what Hospice facilities types should be included. Group will work on first draft that group will review. Need to learn a little more about what Palliative Care units outside the hospital are and really mean in terms of their implications within the Hospice Facility Chapter.

d. **Group 4: Assisted Living: 3 people: Chris (Scribe: Bring Laptop), Howie, Ashley, Steven H. (Frank & Eric as required)**
    i. Review and clarify Appendix language for Assisted Living centralized and decentralized language based upon Small, Medium and Large.
    ii. Review soiled utility and clean utility for Assisted Living. Evaluate to see if requirements may be too clinical in requiring a flush rim sink.
    iii. Pioneer Network discussion follow-up:
        1. Can soiled utility rooms have more flexible requirements?
        2. A4.2-5.1 Building Codes AL: Smoke barriers subdividing every story into at least two smoke compartments. Such smoke compartments should be not more than 22,500 square feet (2.09 square meters), and the travel distance from any point in each smoke compartment to a smoke barrier door should not exceed 200 feet (61 meters). [Evaluate against new NFPA requirements from Rothschild's task force]
        3. Evaluate the following as potentially being operational in nature versus the specific design criteria required:
            a. 4.2-6.2.3.6 Portable hydrotherapy whirlpools. When portable hydrotherapy whirlpools or basins are provided, they shall not be drained into hand-washing stations or environmental services sinks. A dedicated sink or drain shall be provided or they shall be drained in a soiled utility fixture (hopper or flush rim sink).
        4. For ALF, small and medium scale facilities, evaluate correlation between insulation for small and medium sized units as correlated with IL.
        5. Evaluate inclusion of smaller scaled settings for Developmentally Disabled.

6. Group evaluated centralized vs de-centralized language within the building types and cleaned it up. Looked at clean and soiled utility requirements and modified to allow for more residential small environments. No language change for smoke barriers. Looked at hydrotherapy and suggested minor modifications to the language especially for smaller settings. Added characteristics for small, medium and large groups.
    a. Worked with Group 2 to discuss facility types for developmentally disabled to provide language for the new chapter. Howie and Chris followed up with NCAL contact information for assistance. (Subsequently, provided introduction to Dana Halvorson (dhalvorson@ahca.org), who is the AHCA person with oversight of MRDD members.)

e. **Group 5: Non-Residential Group, Specific Spaces & Specific Details: 3 people: John (Scribe: Bring Laptop), Leisa, Phil**
    i. Chapter 5.4: Evaluate square footage for "individual area". In HOP book this is 60 square feet versus 80 square feet that we have in the residential book. Maintained the 80 sq ft, but recommend reviewing in proposals for 2018. 80 square feet may be accurate, because of the population.
        1. Response: Discussed therapy areas. Consensus was that mobility equipment contributed to the increase over 60 s.f. referenced in HOP book. This is referenced in the appendix material. No change needed.
    ii. Adult daycare: 40 square feet toilet room requirement.
        1. Change per mark up in **5.2-2.3.3.4** 40 square foot requirement arbitrary. Better to give flexibility for variety of scales of settings. Visual access more important because of high incidence of users with cognitive impairment.
        2. **PROPOSAL REQUIRED.**
    iii. Treatment and Diagnostics section per discussion above; including evaluation of terms: Treatment Room, Examination Room, and Consultation Room. Evaluate for the Non-Residential, as well as all other facility chapters.
        1. Group added language for care consultation room separate from the treatment and examination room language. See 2.3-3.5 language.
        2. **PROPOSAL REQUIRED.**
    iv. Quiet Rooms: Review Quiet Room requirements for different types of Quiet Rooms: group versus observation lay down space versus private room.
        1. Group added appendix information suggesting design considerations for quiet room to prevent self-injury. We felt that the existing language covered the different types of rooms adequately. See A2.3-2.3.7
        2. **PROPOSAL REQUIRED: APPENDIX INFORMATION**
    v. Specific Details:
        1. Door height requirements: 6'-8" evaluate for all types of settings as a minimum. 2.4-2.2.4
            a. Minimum 6'-8" requirement should apply across settings

look through res. guidelines Rob to request update from GA Tech.

b. **PROPOSAL REQUIRED.**

2. Verify 2.5-2.3.2.3 (5) sensors shouldn't be used for residents with dementia.
   a. Okay to leave as is. Memory care residents will not know how to use the sensors.
3. Review 2.5 Humidification section under ductwork for application to LTC. 2.5-3.4.1.2 Duct humidifiers.
   a. Agree with language as stated; however only if duct humidifiers be used, should the requirement be in place. Not applicable to mandate for all types of LTC settings.
   b. **PROPOSAL REQUIRED.**
4. Section 2.5-2.2.4.2 Kitchen grease traps. Evaluate including interior or exterior solutions are acceptable.
   a. Added appendix language.
   b. **PROPOSAL REQUIRED.**
5. Section A4.3-6.4.2.3 Generators.
   a. Where a generator is routinely used to reduce peak loads, protection of resident areas from excessive noise may become a critical issue.
   b. Need to evaluate, as using generators to shed peak loads is not usually done any more because of emissions requirements, as well as the additional fuel usage.
   c. Need to evaluate in all sections, including 2.5.
   d. Group deleted this appendix language because it is not common practice to utilize generators to shed peak loads. Acoustic and other requirements are included in 3.1-6.4.2.2 and 5.1-6.4.2.2
   e. **PROPOSAL REQUIRED**
6. Verify 2.2-2.4.1.3 Section for Walk-off mats. Tom Jung had wanted to re-address. 5.2-2.3.3.4 (2) for evaluation.
   a. Word "all" is problematic. Use of walk-off mats at primary entrances would seem to cover cases where they are needed. There are resident use doors other than resident rooms where walk-off mat use may be problematic.
   b. **PROPOSAL REQUIRED**
7. Evaluate ceiling height requirements.
   a. Group did not see need for any modifications. The language is consistent with IBC.
   b. **NO PROPOSAL REQUIRED**
8. Location of integral base information. Note that often no base is used if concrete flooring is sealed with concrete block.
   a. Group changed language in 2.4-2.3.2.6 to eliminate requirement for coved base and instead seal base to wall and flooring.
   b. **PROPOSAL REQUIRED**
9. Circulation and Clearances:

a. Evaluate the performance clearances required for different spaces in Part 2: Common Elements.
b. Issues with ANSI UFAS Standard issues versus ADA: Federal Access Board
c. Evaluate dimensions for bathrooms and toilet placements based upon work completed at Georgia Tech (Jon Sanford). Issues with ANSI USFAS Standard issues versus ADA: Federal Access Board
d. Group provided the following:
    i. 2.4-2.2.9.1 – Delete the word “all” – as it is not possible to meet requirements of all regulations given conflicts inherent within them.
    ii. 2.4-2.2.9.2 – Delete the word “all”
    iii. A2.4-2.2.9.2(1) – Need to verify dimensions with Jon Sanford research when available. If we do the above, need to add Jon’s research to 1.1.8
    iv. A2.4-2.2.9.2(2)(d) – added “fold down or free standing” to text
e. **FOUR PROPOSALS REQUIRED. FIVE, IF 1.1.8 IS ALSO UPDATED.**

10. Section 2.5-7.2.1 requires that 40% of walls in resident dining and living to be window openings for light and ventilation (Tom Jung asked to review.)
    a. Most building codes define window/light and ventilation requirements for habitable space (where people eat, sleep, etc.) and base it on SF of the room (not wall area). The ICC requires 8% of the floor area be windows, where 45% of that window area needs to be operable. For example: a dining room that is 10’-0” by 20’-0” is 200 SF in floor area. If it has 8’-0” high walls and is enclosed on 3 sides (the two 10 foot sides, and one 20 foot side which is an exterior wall, the other 20 foot side being open to the corridor) there is a total of 320 SF of wall space.
    b. According to the way this section is written, the architect must provide 40% of the 320 SF of walls as windows, or 64 SF. According to the ICC, only 8% of the 200 SF floor area or 16 SF of windows is required. If this section means to apply to exterior walls only, that would require 40% of the 160 SF of wall or 64 SF of windows. Again, the ICC would only require 16 SF of windows (at minimum).
    c. Re-evaluate this as a minimum.
    d. Group suggests: 40% of wall area is not founded. Recommend changing wording to 8% of floor area per ICC and IBC standards. Also would like to change word ‘windows’ to ‘glazing’ as it would include glass in doors.
    e. **PROPOSAL REQUIRED**

11. 2.4-2.3.2.7 Food preparation areas: Evaluate if information needs to go into 2.3.2.6.
    a. Group determined that language is appropriately located. There is no other finish information in 2.3.2.6 and so it is well located. Moving the section would trigger moving wall finish and other information for similar sections and undermine the intent of 2.4.
    b. Moved 2.4-2.2.4.3 Door protection to appendix as A2.4-2.2.4.2
    c. Modified 2.4-2.2.4.4 language to clarify door type.
    d. 3.1-6.9.2 should read Elevator car doors instead of car doors to be consistent with text in other part of code
    e. 4.2-6.9.2.1 should read Elevator car doors instead of car doors to be consistent with text in other part of the code.
    f. **THREE PROPOSALS REQUIRED**

f. **Group 6: Building Systems: 5 people: Jim (Scribe: Bring Laptop), Steven F., Gaius, Eric, Doug**
    i. Verify temperatures for: 2.5-3.7.2 Heating Systems
        1. Facilities shall have a permanently installed heating system capable of maintaining an interior minimum temperature of 72° F (22° C) under heating design temperatures.
    ii. Verify temperatures for: 2.5-3.7.3 Cooling Systems
        1. Facilities shall be configured and equipped with a cooling system capable of maintaining an interior minimum temperature of 75°F (24°C) under cooling design temperatures.
    iii. Duct Humidification Section 2.5-3.5.2.2 application to be reviewed.
    iv. Natural Ventilation: should this be included specifically as part of the residential book?
        1. Lynda B. Herrig: Newcomb-Boyd is interested in following up: LHerrig@newcomb-boyd.com
        2. Connect with Steve Friedman: work through ASHRAE 170 as liaison is part of the Residential Document Group. **(Note: since meeting information has come from Chris Rousseau for evaluation from recommendations on ASHRAE 170. This document has been posted on Box.com.)**
            a. Review Building System Sections in Part 2 and Facility Chapters.
    v. **Group is working on proposal language and looking to move information to beyond fundamentals as appropriate.**
        1. Some chapters included requirements to comply with 90.1, but it is possible that local jurisdictions may not require 90.1 (such as the Independent Living Settings chapter).
            a. **PROPOSAL REQUIRED**
        2. Generally 2.5 and the Building System sections are in pretty good shape, based upon the updates that was completed for 2014.
        3. Natural ventilation – from committee perspective open windows should be fine. University of Chicago study looking at organisms that they find when having open windows. Looking forward to results and will keep

R1: proposals in document posted on box.com.

the group posted. Also may have implications to finishes and surfaces sections.

a. **PROPOSAL REQUIRED. Consider for beyond fundamentals, if more appropriate for additional detail beyond Appendix.**

vi. **Group 7: Bariatrics: 1 person: Debra (off-line) and since meeting Leisa Hardage has joined the Topic Group. Both Debra and Leisa will be part of the Bariatric Topic Group for HGRC, as well as providing information to Residential Document Group that will be used to develop proposal language**.

1. Discuss approach of areas that need to include access versus those that would be part of a dedicated unit.
2. (2) Alternative grab bar configurations: Evaluate if bariatric line item should be moved into Main Body text. Coordinate with Bariatric Design Overlay in 2.2:
   a. *(a) When residents can undertake independent transfers, alternative grab bar configurations shall be permitted.
   b. **PROPOSAL REQUIRED**
3. A2.4-2.2.9.2 (2)(a):
   a. f. Where bariatric design is required, the length of rear wall grab bars should be 44 inches (112 centimeters) and mounted per the ADA *Standards for Accessible Design*. [This is main text with "shall" in HOP] Evaluate if needs to be updated for 2018.
   b. **PROPOSAL REQUIRED**
4. Based upon information from workshop, information and recommendations will be forwarded to Debra Harris for research review to further the language and proposals. Leisa will be copied on correspondence. Strategy for the Residential Guidelines will need to be developed along with Proposals based upon the Topic Group discussions and direction.
5. Note that Bariatrics is established as an overlay in the Residential book.

g. **Group 8: Lighting and Acoustics: 4 people: Asha (Scribe: Bring Laptop), Mandy, Michael, Skip**

i. Evaluate existing language for updates on lighting and acoustics.
ii. Evaluate information that is relevant to older adults, as well as developmentally disabled and / or visually or hearing impaired.
iii. Low Vision Guidelines from Rothschild to be utilized as background information.
iv. Acoustical information based upon the current information from the Acoustic Task Force and research in process.
v. See the following links on recent work completed on Circadian Rhythms research and presentations:
   1. http://www.lrc.rpi.edu/programs/lighthealth/AARP/index.asp
   2. http://www.lrc.rpi.edu/programs/lighthealth/LightOlderAdults.asp
   3. http://www.environmentsforaging.com/article/lighting-indoor-spaces-senior-environments?spMailingID=48492615&spUserID=MTI0MTg3MTI4NjUwS0&spJobID=662536633&spReportId=NjYyNTM2NjMzS0
vi. **Group 8 Recommendations:**

Word document

1. Vibrations table that appears to have migrated over from the hospital should be replaced with something more appropriate.
    a. **PROPOSAL REQUIRED**
2. Eliminate velocity chart.
    a. **PROPOSAL REQUIRED**
3. Speech privacy tables section is very complex. Going to work to simplify.
    a. **PROPOSAL REQUIRED**
4. Wording clarification changes.
    a. **PROPOSAL REQUIRED**
5. Code compatibility potential issue with Guidelines being less stringent than the IBC. Group to verify.
    a. **May require updates and proposal: TBD.**
6. Reviewed lighting portions for color and light in wayfinding, finishes and all other sections.
    a. **Proposals to be developed accordingly.**
7. Design criteria regarding resident stress wanted to augment "light" with flicker, intensity, and other factors. Develop proposals and evaluation of fundamental for main body text, appendix, and/or beyond fundamentals.
    a. **PROPOSALS REQUIRED**
8. Visual cuing issues that have to do with light and color are also missing.
    a. **PROPOSALS REQUIRED**
9. Quiet rooms and agitation reference to light and color will be expanded.
    a. **PROPOSALS REQUIRED**
10. Referencing and adding chart from Low Vision Guidelines.
    a. **PROPOSALS REQUIRED**
11. Need to add information about identifying how to use "the right color" – language, references, etc.
    a. **PROPOSALS REQUIRED**
12. Anticipate coordinating wayfinding information with RP-28 and Low Vision information.
    a. **PROPOSALS REQUIRED**
13. Circadian Rhythm information is still in process. Research is available demonstrating the importance of Circadian Rhythms. Shared information being completed with GSA/Rensselaer Polytechnic Institute.
    a. **Development of proposals and/or language for beyond fundamentals.**

h. **Group 9: Geriatrics: 3 people: Addie (Scribe: Bring Laptop), Bart, Glenn: Changed name to Health, Wellness & Preventive Care:** evaluation of older adults and the design criteria related to utilizing Hospitals and Outpatient Settings. Is this a geriatric issue or a population issue? Example, Kaiser models in California include:
    i. Bigger exam rooms
    ii. Shorter distances to traverse
    iii. Acoustics
    iv. Vision
    v. Equipment – Lifts and rails into the bathroom.
    vi. Dietician
    vii. Furniture

July 9th: Bart to have a meeting. Identifying issues. Check with Pamela. Ellen Taylor: valuable EDAC background. Frequent ad adverse events. Cross comparing outcomes from LTC environments.

Impaired decision making. Addie: conference call prior to the 9th. high priority items. Info with ROI numbers as a benefit for continuum of care.

viii. Visitor Accommodations

ix. Decide how the information should be presented to the Hos
Document Group based upon earlier discussion. Thinking
the other two books or a White Paper that could be referen
books. Placed this under the Health, Wellness, and Prever
perceive that we could inadvertently do a disservice to the recommendations by couching them as a geriatric-specific.

x. What areas within the Hospital and Outpatient Settings should include information on designing for older adults and staffing? Requirements: evidence based solutions. Recommendations: Best-practices. Beyond Fundamentals: Case studies.

xi. Is there anything that we would want to include about geriatrics or gerontology within the Residential Guidelines?

1. Look at the biggest problems experienced in Acute, sub-acute and residential care.
2. Cull environmental mitigators that have demonstrated ability to positively affect those outcomes.
3. Couch suggestions based upon the platform or patient-driven solutions regardless of age.
4. Created a process model that identified negative outcomes and from those evidence based mitigators that would lead to environment Guidelines recommendations across settings. Addie to take the lead on this initiative. (Since the meeting, Bart has a research opportunity within Trinity that he is pursuing with input from Addie and Jane.)
5. Question about whether or not positive outcomes should also be included – proposed process model seems to focus on negative outcomes only. Agreement that text should just say **Care Outcomes**. Also need to make sure **Quality of Life** is a measure.
6. Additional information and diagram included on www.box.com.

VIII. Discussed establishing a Marketing and Communication Committee for the Residential Health, Care, and Support Facilities Guidelines.

a. Outreach to AHJs
b. Outreach to Providers
c. Outreach legislatively
d. Current Adoption:
   i. Delaware
   ii. New Jersey
e. Discuss ideas for furthering adoption.
   i. Contact for CMS
   ii. Contact for Veterans Administration
   iii. Contact for Indian Health Services
   iv. Other agencies or organizations that can support the adoption of the Guidelines and assist with spreading the word about the Guidelines.
f. Jane discussed assembling a plan of action for adoption. If you work in certain States, please forward information about who the contacts are for starting discussions on having the Guidelines considered for adoption.

i. Goal is to identify not only who the contact is, but also what steps would need to be taken to get document adopted (legislative session, AHJ review, etc.).
ii. Work through our AHJs to also figure out what might be required from their experience in different states.
iii. NCAL has a regulatory review that is completed annually. (Since meeting 2013 is available. Checking with Chris and Howie on 2015 version). Pamela also has a document has a starting point that is based on Lois Cutler's research and will forward a copy to Jane.
iv. Discussed what the avenue to work with CMS for adoption would look like. Still seeking a solid contact at CMS so that a presentation could be made for consideration, and work being completed can be considered for adoption (similar to the work completed by the NFPA).
v. Need to think about how we bring a regulatory forum together to educate them about the Guidelines and adoption.
vi. Need to also think about what the value proposition to each constituent might be.
vii. How do we sell the Guidelines as the thing that they have always been missing and would fulfill their mission, goals, gaps, etc.
viii. Should engage marketing consultants to help us with the establishment of a marketing plan. Rob and Doug will get together and discuss this further but need to get the "Why" out there in a variety of forms.
    1. Encourage the group to watch the TED talk by Simon Sinek on YouTube - "Start with Why": http://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action?language=en

IX. Jane would like all of us to let her know if extra expertise is needed to be added for any of the sub-groups or if there is any additional information that is required to complete tasks and ultimately develop proposals.
X. For smaller Groups (1-9), if you want a www.join.me or conference line contact Yvonne Chiarelli (ymchiarelli@yahoo.com) so that a meeting can be set up with coordinates. Yvonne will be our scribe and help us with our on-line meetings and in-person HGRC voting meetings. Yvonne worked with us on the 2014 cycle, as well.
XI. Doodle poll was sent out for next meeting. June 26, 2015 from 1:00 – 2:30 was established for the call.
XII. Thank you and wrap up.

The meeting minutes, herein, documents the understanding of the meeting held on May 13-14, 2015 for the Residential Document Group. If you have any corrections or additional information, please provide within seven (7) days of receipt. After seven (7) days these meeting minutes will stand as the record of the proceedings.

Respectfully submitted by,

Addie Abushousheh
John Shoesmith
Jane Rohde

CC: Attendees
Absentees