#### HEALTHCARE INTERPRETATIONS TASK FORCE AGENDA

#### **DECEMBER 9, 2008**

The Joint Commission Room 335 One Renaissance Boulevard Oakbrook Terrace, IL 8:30 A.M. – 5:00 P.M.

- 1. Call to order 8:30 A.M.
- **2.** Introduction of Members and Guests.
- 3. Review / Approval of June 2008 Minutes (See Enclosure A Page 2)
- **4.** Review of Questions (See Enclosure B Pages 23-26)
  - **A.** Patient Beds Temporary patient holding in the exit access corridor **TJC** (See ITEM B-1 Page 24)
  - **B.** Clinical Laboratory Areas Clarify how provision is intended to be enforced **VA** (See ITEM B-2 Page 24)
  - C. Ambulatory Care Facilities, Medical Clinics, and similar facilities Clarify how provision is intended to be enforced VA (See ITEM B-3 Page 25)
- **5.** New Business
  - Proposed Bylaws (See Page 27)
- **6.** Old Business
- 7. Date / Location for Next Meeting
- **8.** Adjournment (by 5:00 P.M.)

### **June 2008 Minutes**

# MINUTES HEALTHCARE INTERPRETATIONS TASK FORCE

Tuesday June 3, 2008 – 1:00 PM – 6:00 PM Mandalay Bay Convention Center Lagoon K Las Vegas, NV

- **1.** The meeting was called to order at 1:13 PM. The agenda (**See Enclosure A**) was briefly reviewed. No additional questions were posed but several members indicated they would have items under New Business.
- 2. Introduction of members and guests present was completed. Prior to the introductions, it was noted that a new AHJ member representing the state healthcare agency category had been added to the roster since the December 2007 meeting. Those in attendance included.

#### **MEMBER**

#### REPRESENTING

Joseph Bermes\* (ALT) Indian Health Services

Ken Bush\* International Fire Marshals Association

Doug Erickson American Society for Healthcare Engineering

John Fishbeck\* The Joint Commission

James "Skip" Gregory\* Agency for State of Florida Healthcare Administration

Philip Hoge\* Department of Defense

Thomas Jaeger American Health Care Association
David Klein\* Department of Veterans Affairs
Pete Larrimer\* Department of Veterans Affairs

Jim Merrill\*(ALT) Centers for Medicare/ Medicaid Services

George Mills\* The Joint Commission
Dwight Packer\* Indian Health Services

Robert Solomon NFPA

Dick Strub American Health Care Association

#### **GUESTS**

#### REPRESENTING

Mark Berorr Securitech Group, Inc.

Gene Cable Self

Mike Daniel Daniel Consulting, Inc.

David Dagwais

A. Richard Fasano

Nick Gabriele

Virgil Hall

Wentworth Douglass Hospital

Russell Phillips & Associates

Russell Phillips & Associates, LLC

Department of Veterans Affairs

Philip R. Jose P.R. Jose & Associates

Peter Leszczak Department of Veterans Affairs

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<sup>\*</sup> Voting AHJ Member

**GUESTS** REPRESENTING

Chris Mallett Sprenger Retirement Centers

American Health Care Association

Ryan Maynard Direct Supply

Nancy McNabb NFPA

Jim PeterkinHeery InternationalJohn SabourinVA – Network 8

Tom Scheidel Centers for Medicare & Medicaid Services

Ken Schwartz Schirmer Engineering David Soens State of Wisconsin

- **3.** The minutes of the December 5, 2007 meeting (Washington, DC) were approved as submitted.
- **4. Review of Questions.** Eleven questions were submitted as a part of the original agenda. It was noted Item C and Item D (B-3 and B-4) in the Agenda Enclosures had the subjects inadvertently reversed.
  - **A. Inspection of Portable Fire Extinguishers.** This subject relates to time based frequencies for actions like inspection, testing and maintenance. Issues such as "Does a monthly inspection have to be done in the actual month or approximately every 30 days" were discussed.

HITF members noted the range of requirements that are found in the numerous NFPA documents that have a frequency associated with them. The HITF did vote to issue a position on the subject as follows:

**RESPONSE FOR QUESTION 1:** The dates may not necessarily be absolute. The HITF is aware that some NFPA technical committees are starting to look into their time based criteria. In addition, the Joint Commission previously developed their own guidance/tolerances on these sorts of time criteria in the February 2006 issue of EC News.

QUESTION 2 as submitted is deleted.

The HITF notes they had a related discussion on this subject at a previous meeting – See minutes of the June 2005 HITF meeting. NFPA staff will investigate the possibility of creating a staff project to see if there is a way to establish a consistent way to describe frequencies with a tolerance of some sort. Part of any such internal discussion at NFPA would also include a division of responsibility between a "systems" committee and an "occupancy" committee concerning the need to establish a tolerance of some sort.

**B.** Existing Interior Wall and Ceiling Finishes. New interior finish material that is less than 1/28" in thickness is generally exempted from the interior finish requirements (flame spread/smoke developed). Existing interior finish materials are somewhat exempted if they are less than the 1/28" in thickness and if it can be shown that they have properties of a Class A material when tested with inorganic reinforced cement board. It can be difficult to judge these existing installations.

After discussion on the subject, it was determined that this provision really is a matter for the appropriate NFPA Technical Committee to address via Formal Interpretation. The following question, using the same background from the agenda, will be submitted to the Life Safety Technical Committee on Health Care Occupancies.

**QUESTION:** Are existing, approved interior wall and ceiling finishes that are less than 1/28 inch in thickness and that were installed prior to the publication of the 2006 Life Safety Code, required to comply with the requirements of Section 19.3.3.2 (existing healthcare occupancies) or Section 21.3.3 (existing ambulatory healthcare occupancies) of the 2006 edition of the Code?

**C. Existing Fire Alarm Systems.** Select features from the 1999 edition of NFPA 72, National Fire Alarm Code have been applied on a retroactive basis to existing systems. The specific issue relates to a maximum time delay for the alarm initiation. This requirement from NFPA 72 also included an effective date (January 1, 2002). The HITF did vote to issue a position on the subject as follows:

**RESPONSE:** NO. The effective date in NFPA 72 is for new installations installed after the effective date – January 1, 2002. The AHJ has the ability to invoke certain criteria from NFPA 72 on a retroactive basis (See NFPA 72: 1-2.3, 1999 Edition – Exception) if they have determined that a distinct hazard to life or property exists.

The HITF also notes that NFPA 101: 9.6.1.3 (2006 edition) does not require existing fire alarm systems to be updated to meet new requirements.

**D. Storage Rooms 50 Ft**<sup>2</sup> or Less. NFPA 101, in general has special dispensation for certain small ( $\leq 50 \text{ Ft}^2$ ) storage rooms or spaces. This question goes back to issues regarding the amount and type of material that might be found in these areas. The original four questions posed for consideration by the HITF were discussed and it was determined that in each case, a definitive response could not be provided. During the deliberations, the HITF members agreed to develop two new questions to address the substance of the storage criteria.

The HITF voted to issue a response to the revised questions as follows:

**Q 1.** Could a room or space 50 square feet or less and that is storing combustible material, be considered a hazardous area?

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- **A 1. Yes.** The presence of stored combustible materials in a room or space 50 square feet or less does not necessarily result in the room or space being classified as a hazardous area. In some circumstances, the amount and type of combustibles may result in the room or space being classified as a hazardous area by the AHJ.
- **Q 2.** Can these rooms or spaces that are not deemed to be hazardous be open to the corridor if properly protected in accordance with the requirements of NFPA 101: Sections 18.3.6.1/19.3.6.1?

#### A 2. Yes.

**E. Bare Steel.** Select provisions of NFPA 101 permits attic/roof spaces in healthcare occupancies to be constructed of combustible materials in a building that otherwise utilizes all non-combustible materials. For the case and situation presented, the open space utilizes non-combustible construction comprised of unprotected steel frame members.

The HITF voted to issue a position on the subject as follows:

#### **RESPONSE: Yes**

**Editors Note:** NFPA is withholding the posting of this as an HITF position. During discussion of this item at the meeting, the need for the framing to be structurally independent from the rest of the building was brought up. The HITF did not qualify the response. As such, NFPA will not post this item until that issue is resolved.

- **F. Operation of Doors.** The sequence to unlock, unlatch and open a door is covered by NFPA 101 in the Means of Egress chapter (Chapter 7) and with specialized criteria in Chapters 18 and 19 when locking of doors is necessitated for the clinical needs of the patient. In some cases, a releasing latch mechanism might have to be turned (if it is a spring loaded device) and held in position while a door is pulled open. Two questions relating to these circumstances were put forward. The HITF voted to issue a position on this subject as follows:
  - **Q 1. Yes.** Specifically, one of the operations is to release the lock and the second operation is to release the latch to allow the door to be pulled or pushed open.
  - **Q 2. Yes.** It is generally understood that the restriction concerning the releasing operation does not include the opening of the door once the lock is released and the latch is released.

- **G. Fire Extinguisher Inspections.** This item was discussed but no action was taken by the HITF. The elements and issues in this topic were discussed, in part, during a review of ITEM 4A above. No additional action or position is being taken.
- **H.** Alcohol Hand Rubs in Business Occupancies. NFPA 101 has specific criteria for use of these products in healthcare and ambulatory healthcare occupancies. At present, there are no specific provisions to permit (or to prohibit) the sanitizers to be provided in business occupancies, thus the HITF is not in a position to respond to this question. It was noted that the 2009 edition of NFPA 101 will include (pending outcome of Standards Council issuance in July 2008) ABHR placement and use criteria for educational occupancies.
- **I. Locking Arrangements.** This element was handled as a discussion item. The provisions for door locking from the 2000 edition of NFPA 101 are in effect by CMS. The CMS supplemental criteria for door locking that is utilized will be sent to NFPA for future distribution to the HITF members.
- **J. LSC Guidelines, Appendix I.** This element was handled as a discussion item. Appendix I is the CMS, Survey Instrument document also known as the Surveyors Manual. Appendix I is oftentimes referenced in the State Operations Manual. Appendix I is in effect and it can be downloaded from the CMS website.
- **K.** Items Stored in the Corridor. This element was handled as a discussion item. The HITF referred the submitter back to the minutes and interpretations that were completed during the December, 2007 meeting.
- **5.** New Business. Two items were briefly discussed.
  - **A.** VA Representative Pete Larrimer inquired if the members were aware of any type of reliability study or data for fire protection/fire safety systems in healthcare occupancies.
  - **B.** NFPA Representative Robert Solomon noted that with the number of changes and initiatives underway in the delivery of healthcare services in the US, that NFPA is considering organizing a Summit of sorts in the first or second quarter of 2009 to address emerging issues such as:
    - Culture changes in nursing homes
    - Code provisions in modern day healthcare facilities
    - Reorganization of NFPA 99
    - Trends in Residential Board or Care Occupancies (Assisted Living)
    - Trends in home healthcare.
- **6. Old Business.** The issue concerning use of Relocatable Power Taps RPTs (power strips) is still unresolved. Definitions and criteria in NFPA 70 and NFPA 99 have been used by UL to prohibit the use of such devices in patient and resident rooms. The UL Electrical Council and UL Fire Council were presented with an agenda item

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at their May 2008 meetings concerning this equipment. Information from the UL Council meetings will be shared with the HITF members once clearance is received from UL.

- **7. Next Meeting.** Joint Commission member George Mills offered to host the next meeting at Joint Commission headquarters in Oakbrook Park Terrace. A tentative date of December 9<sup>th</sup> was agreed upon.
- **8.** The meeting adjourned at 6:05 PM.

# ENCLOSURE A AGENDA

# HEALTHCARE INTERPRETATIONS TASK FORCE AGENDA

#### June 3, 2008 Lagoon K - Mandalay Bay Convention Center Las Vegas, NV 1:00 P.M. – 6:00 P.M.

- 1. Call to order 1:00 P.M.
- 2. Introduction of Members and Guests.
- **3.** Review / Approval of December 5, 2007 Minutes (See Enclosure A Page 4).
- **4.** Review of Questions (See Enclosure B Pages 17-26).
  - **A.** Inspection Jaeger & Associates, LLC (See ITEM B-1 Page 17)
  - **B.** Existing Exterior Wall and Ceiling Finishes Jaeger & Associates, LLC (See ITEM B-2 Page 18)
  - C. Storage Rooms 50 ft2 (4.6 m2) or Less Areas Storing Combustible Material New Health Care Facilities. Jaeger & Associates, LLC (See ITEM B-3 Page 19)
  - **D.** Existing Fire Alarm Systems Jaeger & Associates, LLC (See ITEM B-4 Page 20)
  - E. Bare Steel Department of Veterans Affairs (See ITEM B-5 Page 21)
  - **F.** One Operation Department of Veterans Affairs (See ITEM B-6 Page 22)
  - **G.** Fire Extinguisher Inspections Department of Veterans Affairs (See ITEM B-7 Page 24)
  - **H.** Alcohol Hand Rubs in Business Department of Veterans Affairs (See ITEM B-8 Page 25)
  - I. Locking Arrangements Health Care Administration (See ITEM B-9 – Page 26)
  - **J.** Promulgation of the LSC Guidelines, Appendix I Health Care Administration (See ITEM B-10 Page 26)

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- **K.** Regulating Items Stored in the Exit Access Corridors Health Care Administration (See ITEM B-11 Page 26)
- **5.** New Business
- **6.** Old Business

Status of the power strip issue.

- 7. Date / Location for Next Meeting
- **8.** Adjournment (by 6:00 P.M.)

# ENCLOSURE B INSPECTION OF PORTABLE FIRE EXTINGUISHERS

# HITF INTERPRETATION JUNE 2008 NO. 1

Document to be interpreted: NFPA 10 (2002) 6.2.1

NFPA 10 (2007)

Edition: 2002 and 2007

Background Information (optional): INSPECTION OF PORTABLE FIRE EXTINGUISHERS

If taken literally, the text in section 7.2.1.2 of the 2007 edition requires that inspections must be performed at an interval not less than 30 days apart. This would allow the inspections to be performed at an interval greater than "approximately 30-day intervals" as was previously required in the 2002 edition. NFPA Committees were instructed to remove unenforceable language, such as the word "approximately." We believe that the removal of the word "approximately" was for that reason because there was no technical justification identified for the change and the proposal did not explicitly show the word to be struck out.(see NFPA 10 ROP, 10-54A, Log #CP-4).

Some AHJs are now requiring that inspection tags include the day of the month so that the 30-day interval can be measured. However, sections 7.2.4.3 and 7.2.4.5 in the 2007 edition seem to indicate that the committee intended for 12 inspections to be conducted, one per month, without requiring a 30-day interval.

#### **Question:**

Is it permissible to document fire extinguisher inspections by indicating the month and year (without the day of the month)?

#### **Answer:**

The dates may not necessarily be absolute. The HITF is aware that some NFPA technical committees are starting to look into their time based criteria. In addition, the Joint Commission previously developed their own guidance/tolerances on these sorts of time criteria in the February 2006 issue of EC News.

# ENCLOSURE C EXISTING FIRE ALARM SYSTEMS

#### HITF INTERPRETATION JUNE 2008 NO. 2

Document to be interpreted: NFPA 72 (1999) 1-2.3

Edition: 1999

Background Information (optional): EXISTING FIRE ALARM SYSTEMS

**Issue:** Facilities are being cited for deficiencies because their existing fire alarm systems do not comply with the maximum time delay of 10 seconds required after January 1, 2000. It is our position that previously approved fire alarm systems installed prior to the adoption of the 2000 Life Safety Code and 1999 NFPA 72 are not required to comply with the 10 second delay requirement after January 1, 2002. Our opinion is based the language in Section 1-2.3 of 1999 NFPA 72, Section 2-1 of 2000 NFPA 101 and good common sense.

#### **Question:**

Are existing fire alarm systems approved and installed prior to the adoption of the 2000 Life Safety Code (NFPA 101) and 1999 National Fire Alarm Code (NFPA 72) required to comply with the 10 second delay requirement effective January 1, 2002?

#### **Answer:**

**NO.** The effective date in NFPA 72 is for new installations installed after the effective date – January 1, 2002. The AHJ has the ability to invoke certain criteria from NFPA 72 on a retroactive basis (See NFPA 72: 1-2.3, 1999 Edition – Exception) if they have determined that a distinct hazard to life or property exists.

# ENCLOSURE D STORAGE ROOMS 50 FT<sup>2</sup> OR LESS

# HITF INTERPRETATION JUNE 2008 NO. 3

Document to be interpreted: NFPA 101 (2000) 18/19.3.6

Edition: 2000

### Background Information (optional): STORAGE ROOMS 50 FT<sup>2</sup> OR LESS

The 2000 Life Safety Code does not classify storage rooms 50 ft<sup>2</sup> (4.6 m<sup>2</sup>) or less in area storing combustible material as a hazardous area in new health care facilities. The language for existing health care facilities is different in that for existing health care facilities, rooms or spaces 50 ft<sup>2</sup> (4.6 m<sup>2</sup>) or less in area, including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction. The difference between new and existing health care facilities is that the 50 sq. ft. rule applies to both repair shops and storage rooms in existing buildings. The 2000 Life Safety Code allows all spaces to open to the corridor, if properly protected, except for patient treatment rooms, patient sleeping rooms and hazardous areas (see Sections 18/19.3.6).

#### **Questions:**

#### **Question 1:**

Could a room or space 50 square feet or less and that is storing combustible material, be considered a hazardous area?

#### Answer 1:

**Yes.** The presence of stored combustible materials in a room or space 50 square feet or less does not necessarily result in the room or space being classified as a hazardous area. In some circumstances, the amount and type of combustibles may result in the room or space being classified as a hazardous area by the AHJ.

#### **Question 2:**

Can these rooms or spaces that are not deemed to be hazardous be open to the corridor if properly protected in accordance with the requirements of NFPA 101: Sections 18.3.6.1/19.3.6.1?

#### **Answer 2:**

Yes.

# ENCLOSURE E OPERATION OF DOORS

#### HITF INTERPRETATION JUNE 2008 NO. 4

Document to be interpreted: NFPA 101 (2000) 7.2.1.5.4, 18/19.2.2.2.2,

18/19.2.2.2.4, 18/19.2.2.2.5

NFPA 101 (2006) 7.2.1.5.9.2, 18/19.2.2.2.2, 18/19.2.2.2.4, 18/19.2.2.2.5, 18/19.2.2.2.5.2

Edition: 2000 and 2006

#### Background Information (optional): OPERATION OF DOORS

Chapter 7 requires that where locks or latches are provided, the releasing mechanism shall open the door with not more than one releasing operation. However, Chapters 18 and 19 allow doors in the means of egress to be locked where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. Note that the use of a key carried by staff frequently will require two operations to open the door (one operation to unlock the door using the key and one operation to unlatch the door using the door handle, see Figure 1 next page).

Often times, equipment such as wander alert systems, which require multiple operations to open a door, are used based on the clinical needs of the patients. Such systems are widely accepted for use in dementia units for the safety of the patients.

#### **Questions:**

#### **Question 1:**

Where the provisions in Chapters 18 and 19 of the Life Safety Code permit locking of doors in the direction of egress travel based on the clinical needs of the patients, is it permitted to have more than one operation to open the door?

#### Answer 1:

**Yes.** Specifically, one of the operations is to release the lock and the second operation is to release the latch to allow the door to be pulled or pushed open.



Figure 1. Door Requiring Two Operations

#### **Question 2:**

<u>Special Hardware</u>: Where the clinical needs of the patients require special hardware (releasing mechanism) to unlatch the door, is it permitted to have more than one operation to open the door?

#### **Answer 2:**

**Yes.** It is generally understood that the restriction concerning the releasing operation does not include the opening of the door once the lock is released and the latch is released.

# **Review of Questions**

#### ITEM B-1

This is a dilemma many healthcare sites are experiencing. A few years ago we stated it was ok to use the intervening room of a suite (looks like a corridor) as a staging area, but now it appears to have moved out of the suite into patient care units. Patient beds in the egress corridor impact egress, so I don't know how we can allow this from an AHJ position.

We have been having extensive discussions with several internal groups related to placing patients in hallways until beds become freed up. The discussions involve the concept of diluting surges in ED that need to be admitted, that is, placing one patient per nursing unit in the hall until beds become available. The staff have identified that this is considered best practice via IHI. We have also had a physician tell us that IDPH told him there is no regulation stating we can't do this?

We have been quoting the Life Safety Code; specifically Section 19.2.3.3 for existing healthcare facilities that requires that corridors be kept clear of obstructions. However, in light of the comments that we have been getting, we have asked the administrative staff if they can document that the act of transferring a patient will put this patient at risk. If the case that transferring the patient to another facility is a risk to that patient then would it be proper to work around the life safety code issues utilizing Interim Life Safety Measures (ILSMs)? The process that I am envisioning would require a detailed standard operating procedure that identifies how we ensure patient safety during the time the patient is in the corridor. We have asked the staff if they have a copy of the where IHI called this a "best practice"? If I get this information soon I will forward it to you.

This is not the first time that this issue has come up. Do you have a written document that identifies that this practice is, or is not acceptable, or do you have any recommendations on how this issue can be addressed? Are we looking in the right direction or are we way off base?

#### ITEM B-2

Code Reference: 2000 Life Safety Code, 18/19.1.2.1

<u>Background</u>: Sections 18/19.1.2.1 establish provisions under which a section of a health care facility may be classified as another occupancy. We have seen these sections of the Code interpreted differently by different authorities having jurisdiction, particularly with regard to clinical laboratory areas. We would like to clarify how this provision is intended to be enforced, especially with respect to lab spaces.

<u>Case</u>: In an existing fully sprinklered health care building of Type II (222) construction a clinical laboratory area will be renovated. The clinical lab area will be separated from the health care occupancy by 2-hour walls and by 2-hour floor construction. There are health care occupancies located above and below the clinical labs, so the lab spaces will be sub-divided into multiple smoke compartments.

The clinical labs will not serve health care occupants for purposes of housing, treatment, or customary access. Occupants of the clinical labs will have access to exits without having to enter the health care area. Likewise, health care occupants have access to multiple exits without entering the clinical labs.

The clinical lab spaces will contain minimal quantities of hazardous materials and would be classified as Class D lab units under NFPA 45. Under that standard, the labs would be allowed to be unlimited in area. They would not be classified as severe hazard spaces per Sections 18/19.3.2.2.

Question 1: Is it the intent of Sections 18/19.1.2.1 to require that the 2-hour wall run vertically through the height of the building?

Question 2: Is it the intent of Sections 18/19.1.2.1 to preclude the clinical labs in this example from being located immediately above or below a health care occupancy?

Question 3: May the clinical labs in this example be classified as a business use and be permitted to comply with Chapter 38 for New Business Occupancies?

<u>Question 4</u>: Are the clinical labs in this example required to comply with the 10,000 square foot suite limitations of Chapter 18?

Question 5: Other than subdivision to comply with the provisions of Section 18.3.7 are the clinical labs in this example required to comply with any other provisions of Chapter 18?

Question 6: Would the clinical labs in this example be required to comply with NFPA 99?

#### ITEM B-3

Code Reference: 2000 Life Safety Code, 18/19.1.2.2

<u>Background</u>: Sections 18/19.1.2.2 establish provisions under which ambulatory care facilities, medical clinics, and similar facilities that are contiguous to health care facilities may be classified as another occupancy. The other occupancy classifications may be ambulatory care or business, as appropriate. We have seen these sections of the Code interpreted differently by different authorities having jurisdiction. We would like to clarify how this provision is intended to be enforced.

<u>Case</u>: A new four-story medical office building of Type II (000) construction is connected to a hospital building of Type II (222) construction by a bridge link. Both buildings and the bridge are fully sprinklered. There is a vertically-aligned 2-hour fire barrier at the bridge connection to the hospital building that complies with Section 8.2.1(1). There are no high-hazard contents in the medical office building.

The medical office building will be used primarily for outpatient services; however, up to 3 health care in-patients may be brought, via the bridge, into the medical office building at any one

time for diagnostic testing. These patients may or may not be litterborne. There is no 24-hour patient care in the medical office building.

Occupants of the hospital building have access to exits without having to enter the bridge or the medical office building. In order to comply with travel distance requirements, occupants of the bridge may enter the hospital to exit.

Question 1: Is it the intent of Sections 18/19.1.2.2 that the medical office building in this example be regulated as a health care facility and be required to meet the construction type and other provisions of Chapter 18?

Question 2: May the medical office building in this example be allowed to comply with the requirements of the local building code with respect to construction type, means of egress, and other provisions?

Question 3: If the medical office building complied with Chapter 38 for New Business Occupancies, would the 2-hour separation at the bridge link be permitted to serve as a horizontal exit for occupants of the hospital under the exception to Section 18.1.2.4?

Question 4: If the answer to Question 3 is yes, what requirements of Chapter 18, if any, would the medical office building be required to comply with?

Question 5: If there were no bridge link between the medical office building and the hospital (i.e., they were not contiguous), and up to 3 in-patients were transported to the medical office building for diagnostic treatment, would the medical office building be required to comply with Chapter 18?

## PROPOSED BYLAWS

## Charter for the Healthcare Interpretations Task Force HITF

#### I. Official Designation

This Charter is established to outline the scope, purpose and objectives of the Healthcare Interpretations Task Force –HITF.

#### II. Scope, Purpose, Objectives

- -The scope of the HITF is to create a platform whereby those entities that regulate the design, building, construction, operational and fire safety aspects of the healthcare built environment have the opportunity to discuss common areas of interest. Those entities that are the subject of those regulatory policies and procedures also are represented on the HITF.
- -The purpose of the HITF is to work towards resolution and understanding of certain interpretations, polices, and procedures that may differ between private sector, state and federal government levels.
- -The objectives of the HITF are, to the extent practicable, have a full and thorough debate on these issues, reach a consensus of opinion as outlined in the HITF bylaws and to achieve acceptance of those opinions by all members of the HITF.

#### III. Duties and Responsibilities

The HITF's continuing duties and responsibilities will be to:

- (1) Consider variations in codes, standards and policies that cause differing interpretations between AHJ members, user members, or both.
- (2) Develop a process to allow for consistent interruptions of similar provisions between AHJ members, user members, or both.
- (3) Conduct the business of the HITF in accordance with the approved bylaws of the HITF.

#### IV. Support to the HITF

The National Fire Protection Association (NFPA) will provide staff and administrative support to the HITF.

# Bylaws for the Healthcare Interpretations Task Force HITF

#### A.1 General

These bylaws are intended to meet the basic requirements for due process and development of consensus for approval of HITF actions relating to the interpretation and clarification of various regulations, requirements and policies as they relate to the regulatory framework and structure of the healthcare built environment.

The bylaws are intended to comply with the NFPA Regulations Governing Committee Projects (the Regulations) and the regulations, policies and related guidance that may come from the regulatory agencies that have a voting position on the HITF. In the event of a conflict, the following shall prevail:

- a) A conflict between NFPA Regulations and those of the regulatory agency, the requirements of the regulatory agency.
- b) A conflict amongst regulatory agencies, either the policy of one of those agencies or NFPA criteria, as appropriate.

#### A.2 Organization of the HITF

The Healthcare Interpretations Task Force HITF shall be composed of eleven (11) members of who seven (7) shall be voting for purposes of establishing HITF pitons and four (4) nonvoting members. Each of the 11 members shall be permitted to designate an alternate member who represents the same organization or entity.

- a) The HITF shall have a title, scope, and an interest classification system for its members.
  - 1) The membership shall be sufficiently diverse to ensure reasonable points of view without dominance by a single interest category in accordance with Section 3.2.5 of the NFPA Regulations
  - 2) The HITF is subject to the NFPA Regulations as outlined in its Charter.
- b) The National Fire Protection Association (NFPA) shall provide support to the HITF.

#### A.3 Responsibilities

#### A.3.1 HITF

The HITF shall be responsible for providing discussion, debate and recommended positions to the member organizations and representatives as outlined in these bylaws. These positions may be in the form of a position on an item or a minute item as well as the other options noted below.

Consistent with the HITF's responsibilities, the HITF shall be responsible for:

- a) Providing a response to a submitted question.
- b) Requesting a Formal Interpretation (FI) to be processed by the appropriate NFPA Technical Committee.
- c) Requesting a Tentative Interim Amendment (TIA) to be processed by the appropriate NFPA Technical Committee.
- d) Recommending that a member of the HITF submit a proposal or comment to be processed by the appropriate NFPA Technical Committee.
- e) Recommending that the HITF refer action on an item to an external organization to see how any concerns might be addressed by that organization.
- f) Adopting HITF policies and procedures.
- g) Responding to requests for questions or comments concerning the myriad codes, standards and regulations that affect the built healthcare environment including but not limited to:

- a. Hospitals
- b. Nursing homes
- c. Long Term care facilities
- d. Ambulatory healthcare facilities
- e. Office facilities (medical office buildings)
- h) Other matters that may arise for consideration and possible HITF action as provided by these bylaws.

#### A.3.2 Support Organization (SO)

The Support Organization shall be responsible for:

- a) Insuring that the HITF operates within the boundaries of the NFPA Regulations to the extent required under these bylaws.
- b) Overseeing the HITF's compliance with these bylaws.
- c) Maintaining a roster of the HITF and a list of subjects, criteria and requirements for which the HITF is responsible.
- d) Maintaining a Website and posting all relevant documents that pertain to the HITF.
- e) Providing a secretary, through the Support Organization, to perform administrative work, including secretarial services; preparation of meeting notices and the handling of meeting arrangements; preparation and distribution of meeting agendas, minutes, ballots and maintenance of adequate records.
- f) Performing other administrative functions as required by these procedures and approved by the HITF.

#### A.4 Officers

The HITF may select the Chair and Vice Chair (if so desired).

The Support Organization shall appoint the secretary for the HITF.

#### A.5 Membership

#### A.5.1 General

As required by these bylaws, voting and nonvoting members shall consist of individuals who are qualified by background, experience and relevance to participate in the work of the HITF. Members shall be derived from the agencies or organizations that have broad representation and appeal to those constituent groups that have a direct interest in the healthcare environment.

#### A.5.2 Term of Service

In general HITF appointments are for an unlimited term

a) Members completing a term as determined by the organization they represent shall continue to serve until a new appointee has been named.

#### A.5.3 Application

A request for membership on the HITF shall be addressed to the Chair of the HITF and shall indicate the applicant's direct and material interest in the HITF's work, qualifications and willingness to participate actively.

#### A.5.4 Review of Membership

The Support Organization shall review the HITF membership list annually with respect to the criteria of Section A.5.

- a) Members are expected to fulfill obligations of active participation.
- b) Where a member is found in habitual default of these obligations, the Chair shall direct the matter to the HITF for appropriate action, which may include termination of membership.

#### A.5.5 Observers and Individual Experts

Individuals and organizations having an interest in the HITF's work may request to participate as observers or members of subcommittees. The HITF may also select individual experts to assist it as follows:

- a) Individual experts selected by the HITF may be permitted to assist the HITF on an ad-hoc basis and shall be subject to approval by vote of the HITF.
- b) Observers and individual experts may be advised of the HITF's activities, may attend meetings, and may submit comments for consideration, but shall have no vote.

#### A.5.6 Organizational Categories

Each of the eleven (11) statutory categories of members (VOTING AND NONVOTING) shall have the opportunity for fair and equitable participation without dominance by any single interest category.

- Each member, including any designated principal members, shall represent an interest category in accordance with the HITF's established categories.
  - 1) **Voting Members (Authority Having Jurisdiction- AHJ Members)** seven (7) individuals who represent the regulatory and enforcement aspect of healthcare occupancies including:
    - i. Centers for Medicare and Medicaid Services (CMS)
    - ii. Department of Defense (DOD)
    - iii. International Fire Marshals Association (IFMA)
    - iv. Indian Health Services (IHS)
    - v. The Joint Commission (JC)
    - vi. At large State Healthcare Agency (SHA)
    - vii. Veterans Administration (VA)
  - 2) **Nonvoting Members** four (4) persons representing user and general interests, such as organizations that are regulated by the organizations above or that develop regulations that affect the healthcare environment including:
    - i. American Health Care Association (AHCA)
    - ii. American Society for Heath Care Engineering (ASHE)
    - iii. National Fire Protection Association (NFPA)
    - iv. Chair of the NFPA Technical Committee on Health Care Occupancies (NFPA)

#### A.5.7 Membership Roster

The Support Organization shall maintain a current and accurate HITF roster and shall distribute it to the members at least annually and otherwise on request. The roster shall include the following:

a) Title of the HITF and its designation.

- b) Scope of the HITF.
- c) Support Organization: name of organization, name of secretary, and address(es).
- d) Officers:
  - 1) Chair
  - 2) Vice-Chair
- e) Members: name, address, and business affiliation of individual member(s).
- f) Interest category of each member.
- g) Tally of interest categories: total of voting members and subtotals for each interest category.

#### A.6 Subcommittees

Subcommittees may be created to expedite the HITF's work, subject to the following restrictions:

- a) Each subcommittee is created only upon authorization by the HITF;
- b) Whenever the HITF desires to create a subcommittee, it shall be discussed with the HITF;
- c) The HITF shall clearly state the size, scope, and duties of the subcommittee. The current scope and duties of each subcommittee shall be noted in the minutes of the HITF where the subcommittee was created.

#### A.6.1 Chairperson and Members of Subcommittees

The Chair of the HITF shall appoint the chair and members of a subcommittee.

- a) The HITF shall review the scope, duties, and membership of all subcommittees.
- b) Except for the chair, the members of a subcommittee need not be members of the HITF.

#### **A.6.2** Approval of Subcommittee Recommendations

Draft recommendations for proposed action shall be referred to the HITF for review and subsequent action under A.8.4.

#### A.7 Meetings

Meetings of the HITF and its subcommittees, if any, shall be held as necessary, as called by the HITF or as approved by the Support Organization.

- a) Said meetings shall be held to conduct business, such as making assignments, receiving reports of work, considering submitted questions, resolving differences among various enforcement agencies and considering views and objections from any source.
- b) Meetings shall be requested to be held at a frequency sufficient to timely address all actions noted above and may be requested by a majority of the HITF members or the Chair.
- c) Meeting shall be held as face to face, conference call, web-based or other media that is readily accessible by the members.
- d) Draft minutes of all meetings shall be provided from the SO within sixty (60) days of said meeting and distributed to all HITF members. Draft minutes shall be reviewed and acted upon at the next regularly scheduled meeting of the HITF.

#### A.7.1 Open Meetings

Meetings of the HITF and any subcommittee shall ordinarily be open to the public, and meetings of all other

subordinate bodies shall be open to all members and others having a direct and material interest.

- a) At least fifteen (15) days notice of regularly scheduled meetings of the HITF shall be given by the Support Organization on the HITF website, and in other media designed to reach directly and materially affected interests; or in both.
  - 1) The notice shall describe the purpose of the meeting and shall identify a readily available source for further information.
  - 2) An agenda shall be available and shall be published or distributed in advance of the meeting, or both, to members and to others expressing interest.
- b) Participation at meetings shall be limited to the members of the HITF. The chair shall be permitted to allow participation by non members who wish to express a viewpoint on a given topic or issue.

#### A.7.1.1 Closed Meetings

Meetings of the HITF shall be closed only in limited circumstances and in accordance with applicable law.

- a) Where the HITF has determined in advance that discussions during an HITF meeting shall involve matters about which public disclosure would be harmful to the interests of the Consumers, Industry, Government, or others, an advance notice of a closed meeting, shall be published on the HITF website.
  - 1) The notice may announce the closing of all or just a part of a meeting.
  - 2) If, during the course of an open meeting, matters inappropriate for public disclosure arise during discussions, the Chair shall order such discussion to cease and shall schedule it for closed session.

#### A.7.2 Quorum

A majority of the members of the HITF shall constitute a quorum for conducting business at a meeting. A majority of the voting AHJ members of the HITF shall constitute a quorum in order to proceed on establishing a position on a given issue. If a quorum is not present, actions shall only be taken subject to subsequent confirmation by letter ballot or recorded vote at a future meeting.

#### A.8 Voting

#### A.8.1 Single Vote

No member of the HITF shall have more than one vote. Voting by proxy shall not be permitted.

#### A.8.2 Actions Requiring Approval By a Majority

The following actions require approval by a majority of the membership of the HITF either at a regularly scheduled meeting or by letter ballot as listed herein:

- a) Recommending that the HITF address a particular issue.
- b) Adoption of HITF Bylaws, or the revisions thereof.
- c) Recommending that an item be referred to an outside organization or agency for more information or resolution.
- d) Recommending that a member of the HITF refer an item or other matter to the appropriate NFPA Technical Committee to process a Formal Interpretation (FI), Tentative Interim Amendment (TIA), proposal or comment.

#### A.8.3 Actions Requiring Approval By a Two-Thirds Margin

The following actions of the HITF require a letter ballot or an equivalent formal recorded vote at a meeting and approval of two-thirds of the AHJ voting members eligible to vote:

 a) Approval of proposed positions on questions and subjects that are submitted to the HITF for discussion and resolution.

#### **A.8.4.** Voting on Positions

Submission of proposed positions or interpretations rendered by the HITF requires approval of two-thirds of the AHJ members eligible to vote.

#### A.8.4.1. Voting at Meetings

The requirements of A.8.2, A.8.3 and A.8.4 shall also apply to votes taken at meetings of the HITF except, the approval margins shall be based on the number of voting AHJ members present.

#### **A.8.4.2. Authorization of Letter Ballots**

A letter ballot shall be authorized by either of the following:

- a) Majority vote of those present at a HITF meeting.
- b) The Chair.

#### A.9. Disposition of Views and Positions

When voting has been completed, the Chair shall forward the results to the HITF. The results shall be posted to the HITF website. In addition, the positions shall also be conveyed in the publications, websites and other media of the HITF member organizations.

#### A.10 Termination of the HITF

The HITF may only be terminated by a vote of the HITF members.

#### A.12 Parliamentary Procedures

On questions of parliamentary procedure not covered in these procedures, the NFPA Regulations Governing Committee Projects and *Robert's Rules of Order\_*(latest edition) may be used to expedite due process.

#### A.13 Bylaws Review

The HITF Chair shall appoint a Task Group of three (3) members to review and provide proposed revisions and of these Bylaws every three (3) years from the year of last revision.