# *Healthcare Interpretations Task Force*
# *DRAFT MINUTES*
## Conference Call
## April 3, 2020
## 12:30 P.M. to 2:30 P.M.

**2.** The meeting was called to Order at 12:30 P.M. by Robert Solomon.

**2.** Introduction of Members and Guests. The introduction of members and guests was completed. Those in attendance included:

| **MEMBER** | **REPRESENTING** |
|---|---|
| Chad Beebe | ASHE/AHA |
| Joseph Bermes* (ALT to Samuel Vega-Cotto) | Indian Health Service (HIS) |
| Ken Bush | Maryland State Fire Marshal's office — representing International Fire Marshals Association (IFMA) |
| Michael Crowley | JENSEN HUGHES – Rep. Health Care Facilities Correlating Committee |
| William Koffel | Koffel Associates, Inc. – Rep. TC on Health Care Occupancies |
| Pete Larrimer* (ALT to David Klein) | US Department of Veterans Affairs |
| Herman McKenzie* | The Joint Commission – SIG |
| James Merrill II* | US Department of Health & Human Services (CMS) |
| James Peterkin | TLC Engineering-Rep. NFPA Health Care Section |
| Ajay Prasad | JENSEN HUGHES – Rep. American Health Care Association |
| G. Brian Prediger* | US Army Corps of Engineers |
| Kelly Proctor* | Det Norske Veritas Healthcare (DNV GL) |
| Robert Solomon | NFPA |
| Samuel Vega-Cotto | Indian Health Service (HIS) |
| John Williams* (ALT to C. Schlegel) | Washington State Department of Health State Health Care Agency (SHA) |
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| **ALTERNATE MEMBER** | **REPRESENTING** |
| Greg Harrington (ALT to R. Solomon) | NFPA |
| David Hood | JENSEN HUGHES – Rep. American Health Care Association |

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| Justin Schwartz* (ALT to B. Prediger) | US Army Corps of Engineers |
| Brennan Scott* (ALT to K. Proctor) | Det Norske Veritas Healthcare (DNV GL) |

*AHJ Member

**GUESTS**

| NAME | REPRESENTING |
|---|---|
| Bruce Abell | US Army Corps of Engineers |
| Mike Daniel | Daniel Consulting |
| Jim Hogenson | US Army Corps of Engineers |

**3. Agenda.** This call was organized as a follow-up from the March 30 meeting to provide the status update and to report in any updated or new information.

**4. Organization Update. Status/New Items**

**a. NFPA-Robert Solomon.** NFPA has been working internally for several weeks to determine how to identify and best present information related to the current and ongoing challenges in this issue. The present approach is to layout information in three distinct steps as follows.

1. We have a two-page fact sheet that introduces the fundamental challenges associated with trying to apply relevant NFPA codes, predominantly NFPA 99 and NFPA 101, to the range of challenges facing health care providers, AHJs, designers and contractors who are working to construct these temporary configurations. It will include some fundamental background coupled with a list of the resources that we have been collecting over the past several weeks, including information provided by the HITF on the March 30 call. That should be posted at any time.

2. A white paper is currently under legal review that expands on information and the fact sheet, and begins to discuss more of the regulatory challenges, provides background on considerations and use of equivalency provisions is found in the NFPA codes, and begins to expand on several examples of where extreme flexibility related to strict application of codes needs to be considered. It is anticipated that will be released late today or perhaps over the weekend.

3. The third document is a summary of the types of compliance questions or challenges that are known at this point coupled with a guidance and discussion portion that can be considered or utilized by those involved in this complex process. Although the initial discussions on Monday were based upon utilizing NFPA 551, *Fire Risk Assessment* as a model to devise something like this, it became readily apparent that it would be a long-term project that would likely take weeks if not months to prepare. It was noted that the discussion on Monday

specifically referred to utilizing a decision tree of some sort, and that is actually NFPA 550, *Guide to the Fire Safety Concept Tree*. NFPA also decided that this document could move forward without involvement of FPRF. Bill Koffel did receive a draft of the prototype and IT is also undergoing a technical review at NFPA.

A question was posed if the recently issued guidance in fact sheet dealing with remote video inspections (RVI) will be included in the NFPA messaging related to this aspect. The RVI information is essentially directed at ongoing, new construction rather than ITM issues. It is intended to allow for RVI technology to be considered when an inspector or code official could not get to the construction site for whatever reason. Members of the HITF will be notified when these documents are available and posted to the NFPA website. They will likely be on our COVID-19 resource page but will also be shared on other parts of nfpa.org.

**b. DNV-GL-Kelly Proctor.** We were unable to get an update from DNV on Monday due to the represent of being called away. They maintain a daily call with CMS to help provide guidance to their clients and vendors regarding many of the on-the-fly changes that are underway at the client facilities. These calls predominantly deal with getting clarification and guidance around the 1135 waivers that have been issued either for broad topics or on a state-by-state basis. They are also seeing the challenge of vendors not being allowed to enter facilities to do normal ITM activities. The fact sheet issued by NFPA dealing with ITM offers good guidance and shows the importance of trying to maintain a regular schedule or frequency of these actions, but it apparently is difficult to convince state or local agencies that this level of service is an essential function. In addition, other HITF members have previously noted that the resources within the facility that typically deal with building systems and components are also stretched thin given all of the other design modifications, and operational challenges that are being faced. DNV understands that CMS is working on something to specifically address this part of the challenge.

**5. Discussion Items**

Chad Beebe: TJC has submitted a request to CMS to adjust/defer certain inspection and ITM frequency requirements in the TJC EP standards. That effort is to get a blanket 1135 waiver related to these items but at the same time ASHE members are encouraging their individual facilities and state organizations to also submit letters of support for this approach. Chad also noted the information that was just provided by ICC concerning ongoing permitting and inspection issues as well as requests for code equivalencies.

Mike Crowley: DOD developed a performance-based analysis and evaluation related to ITM (circa 2000). That criteria was included in the unified facilities code but it exempted healthcare occupancies. That information was also referenced and utilized in part of the 2018 FPRF report on Reliability Based Decision-Making.

Ken Bush: As part of the approach to modify the ITM challenge, can you look at identifying specific types of inspections for specific critical functions and limit those inspections

to non-patient care areas? For example rooms or spaces containing sprinkler system risers and fire alarm control panels as examples.

Chad Beebe: While approaches like that would work under certain circumstances, the on-site facility in engineering staff members really have no ability or time to set those types of inspections up.

Ajay Prasad: Agree that even trying to set up inspection by outside vendor is challenging due to restrictions imposed by the facility. LTC facilities are also trying to determine how to get other types of expertise on-site to evaluate enhanced measures such as environmental control/isolation spaces. These elements are typically not been part of the LTC facility design consideration.

Robert Solomon: CMS has issued a restriction on visitors to LTC occupancies which may be interpreted by some states to include groups such as ITM contractors. Patient and level of patient care that will be needed.

Jim Hogenson: USACE guidance continues to be updated based upon the type and intensity of patient care that will be needed. While they continue to work with state and local agencies as part of the facility conversion projects, changes and questions come in almost every few hours. For facilities that will be treating COVID-19 patients, those individual patient spaces will have to be fully enclosed. Enclosure spaces include combinations of noncombustible/limited combustible construction walls between spaces, FRP separation panels, or in some cases a tent type structure. Once the patient care spaces ends up with any type of ceiling or overhead obstruction, USACE guidance now looks to have sprinkler protection inside the individual patient care space. This requires modified sprinkler system design such as supplying sidewall sprinklers through the back of the enclosure (ceiling or overhead portions of the enclosure cannot be penetrated) with CPVC pipe and supporting it off of a domestic water supply. Suggested design criteria is for three patient care spaces, each space requiring a single sprinkler. These configurations will be supplemented with items such as smoke detection, line of sight visibility from nurses stations into the patient care spaces, and a fire watch. Due to the variations and configurations that are possible, USACE criteria now requires the project contractor to retain the services of a fire protection engineer to evaluate the special or unique circumstances that may be involved. Other design configurations that are predominately for ambulatory patients who still have capability of self-preservation but need to remain in a healthcare environment, tend to be somewhat more manageable.

Brian Prediger: USACE guidance has recently been updated to also allow the use of pods as part of the patient care space. That information is now contained in the project work statement.

Chad Beebe: As new information continues to emerge, it is almost certain that many of these alternate care facilities or sites will ultimately need to have a piped medical gas system. E cylinder use may require up to 20 cylinders per day per patient which is not sustainable.

Multiple Members: Several questions surrounding the need for only providing high-pressure oxygen? Or will these systems also need to include vacuum systems and medical air systems as well? NFPA 99 criteria is very straightforward if the need is only for high-pressure oxygen as you have no risk of cross connection. Piping enjoining methods regardless of the type of medical gas system required need to be completed using something other than braised joints. Depending on the type of ventilator, medical air may be necessary to provide if the ventilator does not have a self-contained compressor unit. This will have to be a consideration as part of the acquisition and supply chain when ventilators that will be utilized in the temporary sites are being acquired. Vacuum system will not be required as anything that is needed with regard to this can be achieved with portable machines and devices.

Justin Schwartz: What type of occupancy classification approaches should be considered for the repurposed buildings and structures? The hotel conversion project is no longer being operated as a hotel, yet it won't fully meet the requirements for healthcare occupancy.

Scott Brennan: It may be good to have a category of some type to clarify when some special rules may be applicable.

Bill Koffel: A starting point should be to apply the requirements of chapter 19 of NFPA 101 to the nonhospital facilities and buildings and then work from there. Applying chapter 18 criteria of the code to these locations is not feasible. As reminder, the CMS 1135 waivers for these configurations require that a "reasonable" level of care (and safety) be provided.

Jim Hogenson: Agree in principle with that is the starting point, however USACE is encouraging state and local jurisdictions to seek out sprinkler protected alternative sites. Many of the provisions in the USACE "Binder" are based on sprinkler protected buildings, but we recognize that chapter 19 of NFPA 101 does not require sprinklers in every circumstance. This supports the USACE provision to have an FPE on the project.

Ken Bush: Agree that chapter 19 of the code should be the starting point. Typical key issues such as door width in court or with an space are likely not as crucial as the anticipation is that patients will not be moving in and out like they might in a regular hospital under usual circumstances.

Multiple Members: Hotels for example will have/should have a built-in fire alarm system, smoke detection in common spaces, smoke alarms in individual rooms, self-closing doors, and storage areas and spaces with the proper fire rated construction.

Justin Schwartz: Agree that starting with chapter 19 provisions is a better approach and work from there. Is there any need or concern about what the base occupancy requirements or rules are?

Bill Koffel: There is no need to worry about other features or requirements based upon the original or foundational occupancy classification. Hotel guests will not be at the facility once it has been converted to an alternate site. The same is true of the convention center model as well.

Ken Bush: Make sure that the systems and provisions that are already in existence in the building are not reduced or removed — for example make sure that the smoke alarm that would be found in a hotel guest room is kept in place. Keep the existing safety systems in these alternative sites in place and work to accommodate or enhance the available features or systems to the extent feasible.

**6. Next Steps.** Robert Solomon will follow up with the HITF as the NFPA information becomes available. Will also plan to reach out to several members to review the approach being considered for the compliance question document. Based upon the progress, will schedule a call for the week of April 6.

**7. Adjournment.** The meeting adjourned at 1:54 PM.