Welcome everyone and thank you for joining us on our Session 3 of a four-part session with the Office of Statewide Health Planning and Development. Today we have Mr. Richard Tannahill once more and we will be going over the Building Code Part 2, in all of its entirety with that being said, I want to ask you to hold your questions until the end. If you do have a question and you want to make sure it gets answered please type your question into the question dialog box within the go to webinar software and we will try to answer all the questions at the end, in the order that we received them today. Again, once again thank you for joining us and with that being said Mr. Richard Tannahill please proceed. Hello everyone welcome back. If you've been here before and welcome to all first timers today we're going to be going over the 2019 California Building Standard Code, Part 2 changes that were applied back in January. First, we're going to give you a real quick update what's going on with what we're doing with the coronavirus. Actually, things have slowed down a lot for OSHPD. We've been assisting in getting some of the temporary hospitals up and running in temporary conditions available for any surge patients. I'm happy to say that they're not being used a lot right now. Hopefully, that will continue. A lot of the questions we're getting are, if we're still doing plan review. And yes, we are. Our staff, most are working from home, they do have equipment at home but it's not at the same level of what we have here. So, things are a little bit slower. You may see a little bit of delays on your reviews but...
so far, I think they've been pretty good at keeping up.
With the 2019 timeline it went into effect
January, 1st of this year
we have been doing a lot of outreach training on the changes that were coming both before it came into effect and up till now and then we'll continue to do so
but here we are. We're out here now, and we're currently working on the next iteration of this is the 2019 Triennial Code Cycle. What we do when we put codes together is, we take the International Building Code and the last cycle of the code, which in this case the 2016 Building Code and we take any new additions or modifications and scrunch those altogether. That gives us our new 2019 code volumes.
Today we're going to be focusing on Part 2, Building Code and really just what has changed since the last, 2016. My voice is a little dry today so I'll be taking some sips of water as we Go. So Excuse me for that. We've already had, this is session three of four and we've already had Session 1 was the Intro to 1R and Part 10 and Part 1 and two weeks ago Nancy Timmons, our Chief Fire Life Safety Officer did Part 9. And in two weeks, we'll be wrapping up with the Electrical, Mechanical, Plumbing, and Energy Code. Here's the dates for the Session 1. Just want to remind you again to register for each session independently. And, also, we understand a lot of you are watching this from home now and you will have to register individually, we have upped the amount of participants on the webinar. But there still may be a maximum amount.
It's a first come first sign in basis we are trying to work on that to get it higher and we've requested that, but it may or may not be happening we may max out at 500.

Starting Session 3 I just want to remind you that go ahead and enter your questions into the chat and we will answer those at the end as time allows.

The Part 2 of the California Building Code, this is for me, is my workhorse. This is where we spend most of our time as architects and today we're going to be talking about classification alignment and some structural updates just to start us off. One of the things we did and we've been talking a lot about especially in the first two sessions, we talked about that we added 1R, and this is a hospital building removed from general acute care services. You'll be hearing a lot more about that today because a lot of the revisions that were made throughout in all the volumes had to do with adapting 1R to our uses, we also, back in 2016, we added psyched 1228, psychiatric hospitals has their own section for stand alone psychiatric. This cycle we added OSHPD 5 to designate that use.

Also note here just for clarification OSHPD 1R is not an occupancy it is a building type.

The reason behind that is that we can track it in our system when these buildings are removed they remain under OSHPD jurisdiction and when they're removed from acute care service. We needed a way to track them.

The applications of code goes by the occupancy so, the OSHPD 1, 2, 3, 4 and 5.

In 1983 the Alfred E. Alquist Act, as we call the Alquist Act was developed to basically say that hospital buildings that house patients who are incapable of self-preservation that they must be reasonably
capable of providing services to the public after a disaster. And that's kind of how it's been our charge, with OSHPD. Since then to develop these codes the way we do. So, this will apply to general acute care hospitals as defined in the Health and Safety Code. Again, I'm not going to read all this stuff word for word, kind of just explain it, but it does not include buildings if they provide skilled nursing or psychiatric services only. So, you can have skilled nursing facilities and psychiatric facilities as part of a hospital and these will apply but if they're not, the requirements are not the same.

So, the standards that were set up basically, the charge was that we shall design and construct to resistance as far as practical the forces generated by earthquakes, gravity, and winds. Okay, the Office shall propose proper building standards for earthquake resistance based on current knowledge and provide an independent review of design and construction of hospital buildings. Again, this is really the authority that OSHPD has to do what we do with hospitals. Okay, OSHPD is obligated to use model code whenever and wherever possible. If we feel that these requirements are not stringent enough for the requirements for California and the special conditions within California, with justification. We're allowed to modify that model code if it's deemed to be inadequate. And we must show evidence of that when we propose revisions to the model code. Okay, the model code is for buildings that do not house patients and who have less than the capacity of normal health, normally healthy persons to protect
themselves, nor provide services to the public after disaster.
So basically, there are health care facilities that would not meet the requirement of a hospital providing services for health. That’s where the psychiatric nursing observation units, things like that would not come in.
model code will continue to apply for any other use other than the OSHPD 1 General Acute Services.
Okay, now also the reasons we’re kind of including that here these definitions not only give you the history but also to again, with the 1R, what can be used in those buildings. Once it becomes a 1R building it does go back to model code for plan review and OSHPD will be doing those plan reviews for whatever it might be in those spaces.
In Chapter 16 the structural design clarified at OSHPD 2 skilled nursing facilities and immediate care facilities are Risk Category III and this includes all levels of skilled nursing before it was different if it was more than a multi-story it would fall under OSHPD 1 but all skilled nursing facilities now under OSHPD 2. And then we’re just showing here that OSHPD 5 is for the acute psychiatric hospitals.
The component importance factors for skilled nursing facilities, OSHPD 2 and psychiatric hospitals, OSHPD 5 is 1.5 and this is for components that are required for the safety purposes after an earthquake and for medical device components, mechanical electrical components, and components required for life support. Such as subacute beds in skilled nursing facilities.
For this slide basically, we removed the section for occupancies having surgery as emergency
treatment facilities because that actually falls under general acute care hospital buildings. That's the only change here under Risk Category IV. We're going to talk a little bit more about OSHPD 1R allowable services, what's allowed to be in OSHPD 1R building. If they remain for healthcare, you have to remember, the OSHPD 1R buildings remain under the jurisdiction of OSHPD but they also have all acute care services removed from them. So, what would be allowed in there, basically, for OSHPD 1 would be duplicative services under Section 1224, in excess of those required for basic and supplemental services. So, if there's a certain amount things that are required to be part of the basic services within the hospital if you exceed those, those are allowed to go into the OSHPD 1R. You can also put outpatient hospital services, the ones that are listed under 1224.39 for outpatient services, can go in an OSHPD 1R. OSHPD 2 and OSHPD 5 the skilled nursing facilities and psychiatric facilities can also go in a OSHPD 1R because they do not have the same seismic requirements as the acute care facilities. In addition to that almost any other type of occupancy can go into a 1R if it meets the requirements for the model code provisions and for the proper separations between the hospital. So, you can have food services you can have administrative buildings, or clinic spaces, or whatever it might be and again, that will be reviewed under model code. When also doing an OSHPD 1R Building you want to consider what CDPH requires for licensing. Again, the duplicative services they'll be looking at that outpatient observation units are a good
example of what can go into a 1R Building, but may be restricted in the absence of acceptable evacuation provisions and protocols. You need to look at the egress from the spaces and make sure that they're not going back through the hospital. Multiple provider arrangements are another thing that we're seeing a lot of where they'll lease out different floors or different sections of a building to different providers. Things that CDPH is looking at, is how do you enter those separate provider offices or separate suites or uses whatever they might be, and you may have to demonstrate independent support services separate from the hosting hospital. So, they basically have to be self-supportive for their uses. Accessibility has to be considered when you're putting a new use, if you're putting a skilled nursing facility in the 1R, 50% of those beds will have to be accessible with accessible toilet rooms. That's up from 10% if it used to be a med surge unit or similar use. So, that needs to be considered. Existing non-accessible toilets within nursing units when you convert them to staff offices, we're seeing a lot of these patient floors being converted to offices and they basically, end up having their own private toilets. We have talked to DSA and a minimum of 10% of those toilets because a lot of them, especially in the older buildings are not accessible. A minimum of 10% will need to be accessible or made to be accessible and you must also have separate accessible common use toilet rooms in the general area provided that would be within 200 feet.
And nursing unit conversions to family lodging suites will be required to meet the provisions of transient lodging. So that would have to be looked at for the accessibility. So, this is an example of Stanford Healthcare, we did a case study for one of our previous seminars and they turned this building into a 1R Building and this is what they're proposing to do with the different floors. The existing the previous use was all patient rooms and various uses. They turned a lot of the rooms into doctor on-call or physician on-call rooms. Outpatient observation beds were added on the first floor. An outpatient clinic space was provided on the second floor. And their school of medicine offices were added on the third floor, as well as surgical pathology offices. So, you have a lot of different varieties of uses and again, in some cases, facilities may lease out these spaces at different organizations. Here's another example of a case study we did that same seminar and basically, it's Loma Linda University, they're taking their central tower and making it a 1R Building. And in this case on the ninth floor, they're converting into psychiatric space. In the areas in blue. Basically, just designate the areas that had to be upgraded to accessibility to their 10% accessibility, as well as the other blue spaces could be required functional spaces that required for psych that weren't required for med surge. If this was to be a skilled nursing floor, you'd probably see a lot more blue to make 50% of the beds accessible. It's actually 50% of the rooms. Excuse me. So, here's one more case study. This is in San Francisco and the part, you're looking at here is actually the older 1R Building and up on top here we have the new
hospital expansion. So, they want to reuse as much of this older building as possible.
So, this is the uses they put in, they have an existing loading dock, and they asked, can they continue to use that loading dock, now what they did provide a loading dock in the new hospital, much further to the north with a single bay truck. There is no requirement for how many trucks are required in the loading dock. So, they provided a single bay loading dock and they are continuing to use their existing loading dock which holds three to four trucks. Again, this is in excess of what's required by the code for basic services.
Another use they're doing is the outpatient oncology, they can see up to 25% inpatients in this area.
They have a duplicative lab. They have the lab that's required in the building code in the main hospital but they're providing lab services in the existing lab space that was used before. So, they didn't have to demolish or remodel any of this they continue to use it for but as a more of a support service to the hospital. And also, they have duplicative locker Rooms. Again, they have the required number of locker rooms in changing areas in the hospital.
This is just for like general staff changing they can use for whatever they'd like.
So, a lot of reuse here, is with zero construction for this area.
So, what if you're going to put mixed use into these spaces?
What we're looking at, is access, is it public versus patient access, or again, multiple providers or multiple uses.
Will they have their own entries? These are the things that you need to consider when doing this outpatient services, cannot traverse through inpatient nursing units.
So, you can't have
the public walking through an inpatient area to get to their outpatient service may require separate entrances if you have separate providers. Again, these are things you want to talk about beforehand.

Do you need a new front door, or can you reuse the existing one? Again, it depends on where it is on the building how access is gained. Emergency egress, there's going to be, we're going to talk about a little bit more there are requirements for egress not going through the older buildings from the hospital. Elevators may have limitations if you have a psychiatric on the ninth floor you may be required to provide a dedicated elevator just for those psychiatric patients.

You also have to continue to work with the locals for their zoning and land use. Make sure that the use that you want to put in the building is permitted. As well as, will it increase parking demand depending on the use, the locals, that planning department can work with you on those areas. Also, keep in mind vacated spaces. Again, we're trying to emphasize this when you're moving people out or patients out of a space and into the new spaces and you're ending up with vacated spaces, those spaces need to be made safe for nobody being in there. Basically, that you know there is where we did add some requirements for vacated spaces in the code. There is more coming in the Intervening Cycle. There's some clarification on that. Basically, you want to make it so that it's safe with fire separation smoke detection and security.

Again, we talked a lot more about that in the first session and just on a side note here the sessions that are previously done, Sessions 1 and 2, as well as these next two are being recorded and they will be posted shortly. We're working on getting
that done on the OSHPD website. Now we're going into definitions for equipment. We've added fixed equipment, movable equipment, and mobile equipment. This is hopefully going to do a lot to clarify the difference between the different types of equipment and how they're applied. I would also recommend that you look at the new PIN 68 that has been recently posted. You're actually going to see seven definitions or seven different types of equipment listed in that PIN because that's coming in a future code modification but it can be used now. We're going above and beyond the fixed movable and mobile but for the 2019 these definitions have been added. They actually been relocated from the Administrative Code into the Chapter 2 of the Volume 1 of Part 2. That sounds confusing but basically, they they've added them, moved them from the Administrative Code to the Building Code. We added a definition for 1R again just to repeat these are buildings that previously had acute care services that have been removed and remain under the jurisdiction of OSHPD. We discuss means of egress for the hospitals. In addition to the requirements of 1003 means of egress to also comply with Part 10 for Existing Building Code in Section 308A. That's Section 34A of the 2016 Building Code is no longer there, that's the Existing Building Code. It basically remodels, repairs, and renovations, that has all been moved into Part 10 the Existing Building Code. So you want to look at that if you're doing any remodels but basically this section talks about egress from those hospitals not going through from the hospital through these 1R Buildings. But you can go from the 1R back
through the hospital.
Section 1003.1.2 is means of egress for hospitals removed from acute care. Kind of the same thing I just mentioned in addition, the requirements of this, you want to look at section 308 because now the OSHPD 1R Buildings are no longer considered hospitals, 308A is for hospitals 308 is for everything else for Existing Building.
For Chapter 12 means of egress basically, just pointing you to Part 10. Again, the Existing Building Code for the requirements you're going to see a lot of these that say the means of egress or the utilities as you'll see in the next slide will shall only pass through structures that are under the jurisdiction of OSHPD.
That's not the only requirement, so you do need to look at 308A. They talk about, know where it originates. There's other requirements for that but they do have to go through a structure under OSHPD jurisdiction as one of the primary requirements. You'll see that with the service systems and utilities as well, pass through, or under shall only originate in, pass through or go under structure that are under the jurisdiction of OSHPD.
And again, but you have to look at all the pieces together to know exactly what would be allowed there. So, for some of the State Fire Marshal changes that affect OSHPD or acute care facilities is non-patient care suites is back. It's welcome to see that, here's the requirements, they still need the one-hour separation. They're limited 10,000 square feet and they must have automatic fire sprinklers but what you want to look at is under Chapter 10 is the... excuse me, I've got some stuff popped up on my screen here. The definition of non-patient care suite in a group I-2 or I-2.1 occupancies. A group of rooms or spaces within the
suite for use of administrative
business and professional offices. So
you're really limited in these
non-patient care suites
to a more administrative type function.
There's a lot of requests to put
pharmacies in there, they're not
considered patient care
but that would not fall under this
requirement of a non-patient care suite.
One of the other things that have
changed in Section 804,
there was a little break in the code
before where
we were identifying
locked psychiatric facilities at I-3,
that has been changed back to a
locked I-2 or
I-2 with restraint. One of the
requirements under the old I-3, if you
have restraint you are
only allowed to have non-combustible
floor finishes
which was very hard to meet especially
in the psychiatric facilities.
In the 2019 we have clarified that
you may use Class
1 where restraint is used and there
are conditions on that, that have to be
met.
We continue to update the words hand
washing fixtures to hand washing
stations. So, it's all inclusive
everything is required for
for hand washing including your soap and
paper towel dispensers.
And hopefully we caught them all this
time around.
And we also updated the proximity access
terminology and I'll go over those
because
we get a lot of questions on these we
deal with this a lot.
So directly accessible means it's
connected to the identified area or room
through a doorway or other opening
without going through an
intervening room or public space. So, this
would be basically,
you walk through the door here in the
directly accessible space.
Immediately accessible is available
either in the identified area or room
or directly accessible from a room or
area
located within the same department or
service space. So, it can be anywhere in the same department.
Say example, if you're required to put a toilet.
Have a toilet that's immediately accessible it can be in the same department.
And that doesn't mean across the corridor and somewhere else in another department, that means just to clarify that it has to be within the same department or service space readily accessible is located within the same department or service space as the identified area or room or located in and shared with an adjacent directly accessible unit the available on the same floor has gone away. So, this is what's important here to recognize that it has to be located within the same department or service spaces, but it can be shared with an adjacent unit, they cannot be on separate floors. They have to be on the same floor but they have to be next to each other, you can't skip a department. So, again we get a lot of questions on those so, hopefully this will help clarify it. So, service space as shown here clouded, it refers to the distinct area of a health facility where license basic service or supplemental services provided and basically, you can look at these like sections of the code if it's under 1224.27. Those requirements need to be met. Are all grouped together so it shall include all the functional area requirements required to deliver the specific service. Okay, so some general items for further clarification was added for departmental boundaries. Again, it kind of goes back to what we were just talking about with the service areas that everything that's functionally required for that department that's
listed has to be within the department boundary.
So, you may be asked to identify those boundaries.
You can have corridors go through departments but what you don’t want is once a department ends you have a piece of it somewhere else in the hospital.
We also, there's been some updates to this the STC ratings. The sound transmission transmission ratings of walls between rooms.
The patient room is actually dropped and the increase on the exam rooms for HIPA reasons and they added more to the MRI room ratings because those things can be pretty loud.
Clarification of med station locations and observation for these are for the self-contained the Pyxis or other type units.
If provided a MDU or self-medical dispensing unit shall be located at the nurse's station in the clean utility room or in an area where access to the self-contained medical dispensary unit is under the monitoring and control of nursing staff.
So, they have to be in an area that they can be observed by the staff.
So, not in a patient room and it can be in a locked room that staff only has access to, like you said a clean utility room.
Okay, and the self-contained medication dispensing unit should be provided with essential power and lighting. Again, we get a lot of questions on that, they want to throw in the corridor and they don’t have any essential power there that does need to be provided.
The nurse call table has been restructured. This is only a portion of it I would just recommend that you look at the code to see what applies to your project.
I know there's a lot of questions on clinic spaces and where that's required that is still the same as it was previously, but we are
working on 
making that clearer.
So, now we're getting to 1224.
This is a big one for a lot of people
that have required that the nursing
units
not share everything, and this identifies
what can be shared and what's
required to be in each unit.
So, required in each nursing unit is a
nurse station,
an office for the nurse or
supervisor,
a clean and soiled utility room, or clean
linen, a med station
equipment storage facilities for the
different types of equipment,
a nourishment and an ice machine per
unit. What can be shared
is staff toilet rooms, housekeeping
rooms, and
the special bathing facilities, that's
the roll in shower,
or the gurney shower.
Optional services may be shared with
other service bases exam
treatment rooms are optional.
Multi-purpose rooms aren't optional but
they can be shared between departments
and this it says in each area that
should be identified now if they can be
shared or if they must be per unit.
another to me a good clarification,
the code used to say that the locker
rooms for changing for OR's
should be, should ensure
or what you would say, it was
encouraged to be one-way traffic. And now
it says to shall ensure that you'll have
one-way traffic.
So, when someone comes into a locker
room off the street, they'll come in,
change their clothes, and go out on the
other side of the red line.
So, that has been clarified we've been
practicing that for quite a while so, it
shouldn't be a big deal for most people
but that has been clarified in the
language
because the previous language was, is
encouraged
the clinical lab space has been
rewritten. There
previously was only a few items that
were actually required to be in the lab
that has been expanded.
I’m not going to read through all of these but you’re going to have refrigerated storage facilities terminals for sterilization radioactive material handling if required as well as special specimen collection facilities and administrative areas.
When we’re looking at the 1R all of these requirements are now required to be in the hospital building. So, the 1R would be any duplicative services of this or anything additional that would want to be added can be done in the non-acute care portions.
In pharmaceutical we did the A2 Guide I think it’s been a couple years now it’s been out. It is still in effect but we basically transferred all the information in the A2 Guide working with CDPH and the board of pharmacy and we put that into the code now under 1224.19.
So, all these options are listed there we worked a lot with, like I said CDPH and Board of Pharmacy and used other standards to put this together. Even though currently USP 797 is still the new release version is temporarily on hold. They are applying it per the new requirements that are forthcoming and 800 was approved but it basically, depends on 797 to be there. But the A2 Guide is still required to be used. You still required to submit the checklist and the Appendix B is really critical when we’re getting CDPH reviews of these. So, I would encourage you to continue to use that. A new one updated one of these will be posted. There’s not a lot of changes in it, just a lot of clarifications or a few clarifications will be posted probably in the next week or two. But in the code, we’ve added a lot of the requirements that were, you’ve seen in the compounding guides
talk about dispensing facilities,
non-sterile compounding area,
storage non-hazardous sterile
compounding... I'm not going to read
through all of these
but these are the requirements for the
non-hazardous workstations
buffer rooms anterooms and if you're
doing an SCA
it's going to comply with 1250 it's that
graded compounding area,
as well as hazardous drugs the
requirements for that.
And then the support areas that are
required for pharmacies
are identified. Again, the multi-purpose
room can be shared with other
departments
staff toilet rooms and lockers have to
be part of the pharmacy.
And then as before there was always a
clause
in the code that stated if the hospital
has less than 100 beds,
previously it stated that a pharmacy is
not required
which still holds true. But what it
failed to say before that if you don't
have the pharmacy you do
are required to have a drug,
a drug room permit in lieu of a hospital
pharmacy.
We've seen a couple facilities get into
some sticky situations because
they met the requirement of not
being 100 beds but they put the pharmacy
in the outpatient with no
drug room or any area for distribution
within the hospital itself.
So, these items are still required even
if you don't have the pharmacy you have
to at least have a receiving area hand
washing station and storage for those
drugs.
Basically, it's a breakdown area and
distribution area.
For kitchens
just identified and this again, more
clarification food and nutrition
facilities shall be provided support
food services
for staff visitors and patients and
should have adequate space for
preparation and serving of
food shall be provided. Equipment shall
be placed so that
the aisles are sufficient to permit
easy movement and personnel
mobile equipment and supplies when
you're doing a kitchen, I would recommend
this is not
doing anything but I would recommend you do
a functional program specifically for
the dietetic space
because when the functional programs are
sent to CDPH, if they're mixed in with a
much larger project like a hospital,
a lot of the stuff's overlooked. If we do
the pharmacy and dietetic
separately they get reviewed very
quickly. A lot more attention is paid to
them because they have
special units that only work on dietetic
or the pharmacy unit
and they turn these around pretty
quickly for us. So,
I would just recommend you do a
functional program separately
too, for the dietetic and the pharmacies.
Also see here about the infant
formula requirements,
there are some clarifications for
those in those sections
under 1224.29. Which is a NICU
and basically, what it says is the
nourishment room is not required for
NICU's.
Senate bill 1076 was
Approved, it's been a couple years now
which required observation services for
outpatient services
to be added to an emergency department
area that would be considered outpatient.
We did provide a new code for 1224.39.6
and what it basically says is that a
outpatient observation unit can be in a
a
conforming or non-conforming
hospital building.
So, it can be in a 1R Building and
it may be relocated
and it, but the catch here
is the must have a corridor system that
connects to
all the basic services and supplemental
services of the hospital. So, it has to
have a
direct corridor system, so it can't be a
building across the parking lot
even if it's outpatient there should be
a corridor that connects them.
Okay, patient access to this unit should
not pass through public lobbies waiting areas or other departments and that doesn't mean they can't come into the waiting room which means if you're assigning them to go to the observation unit. They shouldn't have to if you have patients, they shouldn't have to go back out into the public areas and back into their more clinical space.
And they shall have the support spaces for the waiting room, public toilets, telephone, and drinking fountain.
And getting closer to the end here Section 1225 for skilled nursing facilities and psychiatric under 1228.
Again, we talk about egress, this again goes back, it's been added because of the 1R, we're talking about egress through these spaces not going through a building that's not under OSHPD jurisdiction.
And again, with the skilled nursing facilities, all of them are now under OSHPD 2 before if it was a multi-story it was under OSHPD 1 is now under OSHPD 2.
As I mentioned earlier Chapter 34A no longer exists. So, you will go to the appropriate 3A, 4A or 5A for those items for the existing structures. That's again for remodels and also 1225.2.2 egress requirements include multi-story that's what I just said that they are now again, the egress is still the same requirements.
Okay, for OSHPD 2 subacute care if you're putting subacute into skilled nursing facilities they do need essential power electrical power at those beds.
Okay, construction if you're really, this is just a note that's been relocated from 1705, but construction documents for OSHPD 2 Buildings without subacute beds, so, explicitly state that skilled nursing facility or Intermediate Care Facilities
do not admit patients needing sustained electrical life support equipment.
Basically, you're saying we're not going to be putting subacute patients in here.
I just want something to document that because if you do add subacute later there are requirements and there's also a CAN that will help you do that if you're going to do that later.
Again, with skilled nursing facilities the system services are utilities that originate in, pass through or under structures unless they're in the jurisdiction of OSHPD as well as the egress will not pass through structures that are not under the jurisdiction of OSHPD.
Again, look at all the requirements when you're doing this this is just for information right now CMS has changed their bed requirement for skilled nursing facilities not to have more than two residents per room, current code allows for four if you provide four right now they may not get reimbursement for those rooms.
Now, we are changing this in the Intervening Cycle to for a maximum bed of number of beds to two rooms in the new upcoming Intervening Cycle to align with this. But as of now this is just a note you can still do it but there may be issues getting reimbursement down the road.
Okay, moving on to acute psych hospitals.
The requirements again previously introduced in the 2016 code are now 1R they're tailored for standalone acute psychiatric hospitals. So, hopefully we don't need all the AMC's to do these projects now.
The common elements that can be shared with acute care hospital are still located in 1224 and they'll be referenced from one to another.
So, that they're not repeated over and
Acute psychiatric basic services currently do not have general acute care services. If you do have medical services then you're going to apply the requirements of a hospital under OSHPD 1. Again, we're talking about utilities the same thing as skilled nursing facilities not originate pass through or under a structure unless it's under OSHPD and the same with egress not going through a structure unless it's under OSHPD jurisdiction. Also, you want to look at the requirements for locked I-2 units, there are a list of requirements that have to be met to have a I-2 with restraint or locked facility. Moving on to clinics. Just added some clarification for the specialty clinics, in addition to primary care being surgical, chronic dialysis, alternative birthing clinics, and rehabilitation clinics. They also added psychology clinics, the requirements for that and this section should also apply to outpatient clinic services of a hospital when provided in a freestanding building. Freestanding building has been added to the definition under OSHPD jurisdiction. So, that you can have these services in a freestanding building and still be under OSHPD jurisdiction but again, there's a bunch of conditions that have to apply, the duplicative services or the outpatient services. This is big for the clinics they have to be continuous functions, just like in the hospital where everything has to be in the same department the same thing applies now with clinics. If you have various functions including to but not limited to reception, waiting staff support areas, such toilets, storage and lounge may be located outside of the clinic suite for the approval with the approval CDPH.
But all the other services that are required for the functional use of that space have to be within the same suite. So, you can't send somebody out of the corridor to get to another area to continue their treatment, it should be continuous. Again, they're making the exceptions that if you're in a shared building you can share reception, toilets, waiting room, things like that. If the toilets and drinking fountains serving the public are provided for the entire building they can be shared in the central area and also these allow some of the services such as storage laundry and housekeeping and waste management to be shared with other tenants. Correctional treatment centers, all we did was add an allowance that gooseneck spouts may be used in appropriate locations basically, where there are no inmates. So, if you're interested in code, we would ask that you get involved. We do have Hospital Building Safety Board, we have the Academy for Healthcare Architecture that we work with. We're interested in hearing what you have to say, if you have issues with the code, how it's written. We'd like you to get involved. Let us know, we can't correct it unless we know there's a problem. Attend those meetings as well getting involved as you're interested. We welcome your attendance, we welcome your input. So, with that we're going to go on to Q and A, before Cesar starts this and… I always get a timer on this slide and keeps changing on me there. I just want to call your attention to the email addresses shown underneath the photo here. If you have further questions or if
you don't get your question answered today you can email us at regsunit@oshpd.ca.gov or fddwebinar@oshpd.ca.gov and we'll try to get an answer to you as soon as we can on your specific question. With that I'm turning it back over to Cesar.

Great thank you Richard. Thank you for that a lot of good information, I hope everyone is enjoying the presentation in the series.

With that being said, please know that we've received a lot of questions that are specific to projects, so we're going to go ahead and try to limit the the questions we answer over the webinar to a more generalized question and answer type, so with that being said.

Richard, I have the first question for you.

Dealing with OSHPD 1 and 1R question is, can a 1R be reclassified in the future as a 1?

Yes, it can but you'd have to do all the requirements of a 1.

Most of the 1R's are being taken out of service because they're not meeting the SPC 1 or 2 requirements or the NPC requirements. It would have to be brought up to full code compliance and it can be brought back to 1.

Now we do have a couple instances where we do have SPC 3 buildings that are just voluntarily being removed from acute care services. Again, you'd have to go through and justify that you're meeting the current code requirements at that time when you decide to bring it back to a 1.

Perfect and thank you for that.

I have another question from the audience also dealing with OSHPD 1 and 1R. Can duplicative surgery suites be located in 1R?

If they're considered outpatient, just to clarify duplicative service for surgery, there is outpatient surgery and if they're connected to the building through the right requirements they can
do
25% of inpatient, but they have to meet the requirements of an outpatient facility. Okay, very good, here's a more generalized question dealing with IOR or inspector of record inspections for projects. Does the remodel work in an OSHPD 1R require IOR inspection and OSHPD field oversight?
You should be able to answer that. We are working on that, it is going to be a different requirement for inspections from what I understand, once the plans will be reviewed there's going to be a different set of requirements for that, actually do you Cesar, I defer that to you. If you know how those are going to be handled yet?
No, you're right Richard, we are working on that, it's the OSHPD 1R is is something that you know it's more of a complicated nature but if the building of the structure remains under our jurisdiction then we would require the IOR inspection, right.
Yes, but we're not going to be going to the same level so that is something we're working on it'll probably have an abbreviated TIO Test Inspection Observation, it will not have the same requirements as the hospital.
so, I guess the answer to that is, yes Possibly, but more to come on that. Next question still dealing with one and 1R, what is your best guess for when CAN 2-11B can be reissued? This relates to conversions of OSHPD 1R and the 10% toilet room noted on your slide just before the Stanford example. It's in the works we have about a couple more things we're working on with leadership to get approval on. I would say it will probably be posted within the next three to four weeks. That's a realistic answer, it may not be
what you want to hear
but it is going to be, we just have some
final things we're wrapping up and it'll
be posted. We have to
also, make everything accessible and
unfortunately, it takes a little bit of
time to do that as well.
Yes, the accessibility requirements are
quite involved too.
So, those of you listening, if just to
give you a little bit of background on
that,
to make any kind of document that a
agency, a state agency puts on a public
website, we need to make it,
make sure that it's accessible and
there's a lot involved to do that.
And that's why the previous
sessions have not been posted yet either.
That's all we're waiting on is getting them
converted to
be accessible. Perfect so switching gears
on to OSHPD 2 or OSHPD 5,
question is, can a dementia,
is a dementia or Alzheimer's OSHPD 2 or
OSHPD 5
and how do you determine which one it is?
It's an OSHPD 2. An OSHPD 5 is going
to be a psychiatric
acute care hospital and OSHPD 2 is a
skilled nursing
facility that you are allowed to
control the patient population for
Alzheimer's and dementia patients
and you are allowed to lock the
doors.
Again, there's requirements to do so and
if you
want to talk to us more about that
we can set up a meeting or you can
contact us but yes, they would be in OSHPD
2. We get them all the time.
Perfect sticking with the same
OSHPD 2, OSHPD 5
subject can a SNF for an acute psych
be done in
1R under the hospital's license without
providing separate entrances
or infrastructure? Can you repeat that
please?
Can a SNF or an acute psych be done
in a 1R under the hospital's license
without providing separate entrances
or infrastructure?
I missed it I apologize I was coughing.
It's okay, SNF's
or acute psych, can they be done in a 1R under the hospital license without providing a separate entrances? Yes, it would be the same as having a distinct part SNF or a psych in a hospital building itself. If you have the 1R you can have the same access to it through the hospital again, you have to look at the egress you cannot exit the hospital through either of those uses but they can actually have the egress coming from the SNF or the psych through the hospital I wouldn't recommend the psych coming through the hospital but those options are available. But yes, it would be treated just as it would a distinct part of a hospital service but it would be under, you can have both of those service under the hospital license in a 1R Building. All right, thank you for that. The next question we have is something that would I that I would anticipate is going to be a very generalized question dealing with old facilities wanting to bring them back into service. So, the question reads how is a building defined if it was taken out of acute care approximately 10 years ago and the facility now wants to utilize this building for multiple uses including SNF and outpatient services to bring this facility back into jurisdiction would it be considered a 1R Building or an OSHPD 2? There would be a lot depending on that if you're taking a building out of service 10 years ago and you lose a license actually, the CDPH requirement for a new license would be bringing it up to the current code standards. If you're bringing in a skilled nursing facility it can be a standalone skilled nursing facility. Now, if it was removed from service and made a 1R you just can convert it to the SNF used just as you would
any other SNF type project. So, but like I said there's a lot of variations to this question a lot of answers that would go with it but basically your your design would have to meet the code requirements for the new use just like you would for any remodel and the building type again it wouldn't be a 1R unless it was removed from acute care service and made a 1R. You're not going to bring an old building and assign it a 1R if it wasn't already there.

Perfect I have another question from the public dealing with renovations, the question is many SNF's are being renovated and turned into subacute, there are no code section or sections dedicated to this only that captures some of the requirements in OSHPD 1 facilities can you help with this? Yes, we actually have a CAN I believe it's a CAN that i don't know the number off hand. And that CAN deals with converting to subacute, it talks about all the electrical, mechanical, and architectural, requirements to do. So, check our website if you can't find it go ahead and send us an email at regsunit@OSHPD.ca.gov and we can answer, get you a copy of that.

But you're correct, it's not specifically addressed in the code and that's actually when we mentioned the subacute in there we did add subacute to critical care for electrical code, and we are adding it, we did add the definitions of subacute and the requirements for electrical to be looked at as we went over earlier. Very good I have another remodel question dealing with Section 1224.7 17.3, question is will remodeling an existing lab, trigger a requirement to add the new functions in Section 1224.17.3? Depends what you define as remodel, if
you're replacing a piece of equipment
no, if you're completely gutting it
and rebuilding it, you're probably going to
have to meet with us and see what would
be required because the
previous requirements for a lab were
minimal at best
and so that is something
that if you're doing a new lab yes, you
have to meet all those requirements.
If you're remodeling it's going to,
it's really going to depend on the
extent
of the remodel and what's being done. you
know, we see a lot of
the new Remodel CAN, we talk
about equipment replacement
which we see a lot of labs just doing
equipment replacement.
But once you start about remodeling,
you're going to need to meet the
functional requirements
of that new lab but again, it's going to
really depend on the extent
of the remodel. So, again that would
probably be a meeting
ahead of time to find out actually
what's going to be required.
Perfect thank you for that. This next
one is more of a clarification
asking for clarification as opposed to a
question.
The comment is, can you clarify
needing to provide
separate functional program for dietary
services?
Yes, that's actually something that's again
it's optional.
It's not required. You do all projects
are pretty much required, most projects
require having a functional program.
I've found personally that if I'm doing
a hospital project,
if I get a separate functional program
that only addresses
the pharmacy requirements such as with
the A2 Guide, if you're just doing a
pharmacy upgrade you would
submit a functional program just for the
pharmacy or if
you're doing a kitchen only, you're
require to do a functional programming
kitchen.
I would also do the same thing if you're
doing a say a hospital project,
do the full functional program and then
submit the pharmacy and the kitchen
in addition to, not instead of, the other
functional program
but in addition to. This just helps
the review process.
Just from my working with CDPH you're
going to get a much
better response, and much better comments
based on that. So, again it is not a
requirement
but the pharmacy one is, but the dietary
is not. I just
found from personal experience if you
have a separate
dietary functional program in addition
to your normal functional program
we can get it pushed through a lot
faster and get comments turned around.
And to be honest most of the new
kitchens that we've been seeing
CDPH is requesting a meeting
to go over it and review it with you. So,
like I said that we're getting a lot of
attention
from the pharmacy and the kitchen
services it's a welcome
attention and it's just a way that I
have found
to help expedite the process and get you
the information you need
sooner. All right
next question deals with the four bed
skilled nursing rooms.
Question is, do you know if the
reimbursement problem
for four bed skilled nursing rooms apply
to existing licensed facilities?
I'm not, again we're not CMS I'm not sure
how they work. I know that
it came into effect 2018 and typically
you have 10 years to comply.
I do not know if it's retroactive or not
but we are going to be requiring that
future
skilled nursing facilities be limited to
two beds. And we're just
kind of giving what we call blue note
comments now
if we're seeing that, my guess is that
the older facilities will be allowed
but I cannot say that for sure. You'd
have to check with CMS
or your licensing. And I wanted to make
sure that, that
we point them to CMS and
then make sure that.
Yes, CDPH would probably be a better one to ask that question of because we're seeing this with high-rise buildings as of 2028 have to be sprinklered and that's also a CMS requirement, has to be fully sprinklered and that is retroactive it doesn't that does not grandfather you into anything. So, they take different positions on that and we would have to check with CMS.

And this next question deals with remodeling and not being able to comply with new code so, daylight and NICU are there alternative methods of compliance for existing facilities that need to be remodeled and can't comply with a direct window? That one we get a lot of questions on. What I would suggest that you meet with us ahead of time and see what allowances there are for that. I know a lot of the older facilities they used to put the NICU's in the center of the building with no windows and it's near impossible to get lighting out and I'm sure there's going to be some allowances or alternate methods of compliance to deal with existing conditions. And again, we're going to be looking at the extent of the remodel, if you're expanding or completely gutting the NICU, we're going to have to look at the space and see what would be reasonable. That's our key word this year reasonable, but that would definitely be something that you would want to meet with us about. I've been getting questions about that recently.

Another question for you. This is a good question since the acute care regulations don't carry into OSHPD 5 is there future consideration of not requiring medical airborne infection isolation rooms since psychiatric hospitals don't admit patients
with those medical needs and transfer patients once they have these medical issues?
There is no current plans to make modifications to the requirements of isolation rooms because they actually are used.
All right next question.
Does the USP 800 apply to medication room inside a nursing unit? does the what?
Does the USP 800 apply to medication room inside a nursing unit? Only for compounding in there.
800 is for compounding hazardous drugs. There are other requirements on 800 for Hazardous, Sterile, non-sterile, things like that. But no, it wouldn't be for your med room. You shouldn't be doing any of that in the med room.
Great, I got a design question for you. Maybe a little involved, for an outpatient dialysis as an I-2.1 under OSHPD 3 is this facility considered as essential facility with an important factor of 1.25? It would still fall under OSHPD 3 Requirements.
All right we do have some more questions that are more specialized and require a more specific, I should say that require a little more research.
So, with that being said I... on that last question though I just wanted to, I didn't directly answer the question about the value because to be honest I'd have to look it up but it would be, it's not considered an essential services as such as a hospital would be. What we're looking at, is a place that you would go after an emergency, after an earthquake, or in an event, is this somewhere you would go. That's why SNF’s and psych hospitals are excluded as well. So, what you're describing as an I-2.1 would not be a place you would go for after an emergency and they would not have the same level requirements.
So, it would have, you'd have to look at the code to see what was required for that type of service for that,
that facility and it's probably not
going to be at the hospital level.
Alright good, I believe I have one more question.
And you may or may not know this off
the top of your head.
What is the definition of restraint
in an I-2? There's a long definition I
can,
it's basically for an I-2 it's going to
be you're either locked in a room or an
area or you're physically restrained
with a soft…
Again, I should probably look up the
actual definition.
But in I-2 you can restrain someone to a
bed or in a seclusion room
only and that room can be locked and
secured.
It doesn't make it a locked I-2. But
once you get into a unit or
you're restricting
somebody's ability to move
more as in the patient and psychiatric
type condition
I would say I would recommend you
look at the definition,
It's under in
Chapter 2 and I can look it up as
you're
going to the next question if you want
but it's basically there's
it's very clear what would be considered
restraint and what would apply and also
if you're
doing any type of lockdown facility
you're going to have to do a
risk assessment for the types of
patients are being seen and that will also
distinguish
or determine the level of
security that you'd have to provide. Yes,
and that's a good example of
something of a question that's
specific and we can provide an answer to
that question
in your individual replies that we
send back to you to those similar
questions.
So, with that being said we are a
little past the hour
on our webinar. I have the definition
here if you want. Yes. I can
read it really quick
like I said it's a little long it's
actually, three paragraphs, I'm not going
to go into the whole thing.
But restraint is the physical retention of a person within a room cell or cell block holding cells temporary holding cell room or area holding facility secure interview rooms courthouse etc. just goes into all these lists by means of a locked door or within the exterior walls of the building. And let me go on to the other definition. Basically, if you're locked in is one. And says facilities employing the use of soft ties however shall be classified as a building used to house non-ambulatory persons, non-ambulatory persons restraint shall not be practiced in licensed facilities classified as, basically are unless constructed to the group I-3 occupancy. And then it refers you. There's again, there's a lot of definitions in Chapter 2 under definitions of restraint. Again, if you have a special circumstance you're curious about go ahead and send an email but we're seeing a lot of questions like if you have an ED with a seclusion room where you put your psychiatric patients in there that is not, that is restraint but there's allowances for that. Thank you for that Richard. A lot of good information and we we here at OSHPD hope that you enjoyed the webinar presentation. Again, if you do have any more questions or you have a specific question or a project you want to discuss please feel free to email regsunit@oshpd.ca.gov or fddwebinar@oshpd.ca.gov and a quick reminder we do have our fourth session coming up May 7th, Session 4 which is going to deal with the California Electrical Code, Mechanical Code, Plumbing Code, Energy Code, how to remove acute care services from the building.
and a little bit more information of what we have coming up. Again, thank you for joining us and we hope that you've enjoyed the presentation today.