

**FINAL STATEMENT OF REASONS
FOR
PROPOSED BUILDING STANDARDS
OF THE
OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

REGARDING THE CALIFORNIA BUILDING CODE
CALIFORNIA CODE OF REGULATIONS, TITLE 24, PART 2**

The Administrative Procedure Act requires that every agency shall maintain a file of each rulemaking that shall be deemed to be the record for that rulemaking proceeding. The rulemaking file shall include a final statement of reasons. The Final Statement of Reasons shall be available to the public upon request when rulemaking action is being undertaken. The following are the reasons for proposing this particular rulemaking action:

UPDATES TO THE INITIAL STATEMENT OF REASONS:

The Office of Statewide Health Planning and Development (OSHPD) finds the following revisions are updates to the Initial Statement of Reasons:

Section 1224.20.2.15 "Toilet room(s) and locker spaces." This sub-section has been amended to require that a separate locker area be provided for dietetic service employee's clothing and belongings.

Section 1226.2 "Application." This subsection has minor modifications to the language for clarity. CBC Section 3401.1 provides for the "alteration, repair, addition and change of occupancy of existing structures, including state-regulated structures." Section 3404 currently provides requirements associated with alterations, and Section 3408 provides requirements associated with a change of use or occupancy. These sections generally require such work to comply with the requirements of the code for new construction with some specific exceptions. The proposed language takes these exceptions into consideration and relates this work directly to the requirements of CBC Section 1226 without necessitating independent research by designers, and agencies having jurisdiction, of Health and Safety Code § 1200 and subsequent determination of what is, or is not, "less hazardous" as applied under CBC Section 3408.1.

Section 1226.4.1.1 "Examination or treatment rooms." This sub-section under 1226.4 is intended to address examination and treatment rooms as general construction common to clinics and outpatient clinical services under a hospital license. Health and Safety Code Section 129885 requires that the building standards for outpatient clinical services of a hospital licensed under §1250 be no more restrictive or comprehensive than standards applied to clinics licensed under §1200. The linkage between CBC Section 1226.4.1.1 and Section 1224.4.4.1 provides the required parity.

Section 1226.4.14 "Support areas for patients." This sub-section is amended to provide clarification and is based on the *Guidelines for Design and Construction of Health Care Facilities*. This sub-section is also amended to provide an exception, for smaller primary care clinics (3 exam/treatment rooms or less), to allow the patient toilet room to serve the outpatient waiting room. This exception allows for the use of an existing exception provided in California Plumbing Code (CPC) Section 412.3 that permits small facilities, serving ten or fewer people, to use "unisex" facilities for public use, in lieu of segregated male and female facilities, and to combine that use with a patient use toilet.

Section 1226.5.5 "Radiological/Imaging service space." This section is added to clarify requirements for outpatient clinical services commonly provided. "X-ray examination services," "Computerized tomography (CT) scanning," "Magnetic resonance imaging (MRI)," "Ultrasound," and "Mammography" have been added as common radiological/imaging service types. Requirements have been tailored as appropriate for a freestanding outpatient clinical services building with references back to Section 1224 when relevant for consistency with those services when provided in a hospital setting.

Section 1226.6.1.1 “Examination room(s).” This sub-section refers to examination rooms described in the “general construction” section of 1224.4, intended for all health facilities. The minimal area of 70 square feet and minimum dimension of 7 feet previously afforded primary care clinics were not compliant with accessibility standards and have been replaced with the universal examination room minimums of 80 square feet, and 8 feet clear, necessary to comply with accessibility requirements, and provide consistency with other sections in the *California Building Code* and with the *Guidelines for Design and Construction of Health Care Facilities*.

INITIAL STATEMENT OF REASONS:

The Initial Statement of Reasons includes the following:

Section 1.10 “Office of Statewide Health Planning and Development.” This section has been amended to correct the listing of the adoption of specific sections for OSHPD 1, 2, 3, & 4.

Section 308 “Institutional Group I Occupancy.” This section has been amended to reflect the International Building Code (IBC) addition of “*Ambulatory care facilities*” to Business Group “B” occupancies, resulting in the deletion of California’s Group “I-2.1” occupancy. OSHPD’s exception relative to structural considerations under Group I-2.1 is no longer needed and has been deleted.

Section 1208.2 “Minimum ceiling heights” This sub-section under Section 1208 “Interior Space Dimensions” provides exceptions for OSHPD 1, 2, 3 & 4. Specific clinic regulations under 1226.4.6 now refer to general construction requirements under Section 1224.4.10. The exceptions have been modified accordingly.

Section 1224.3 “Definitions.” The definition of “gooseneck spout” has been deleted and the definition of “handwashing fixture” has been amended due to redundancy with amendments in the California Mechanical Code. Additional terms have been defined for clarity and consistency.

Section 1224.4.4 “Support areas for patients.” Sections under 1224.4 “General Construction” have been amended to provide a grouping of the requirements for “Support areas for patients.” This will facilitate the presentation of “general construction” requirements intended for all health facilities, that are in addition to the specific requirements under the various types of health facilities in subsequent sections. This proposal is intended to provide additional consistency and clarity.

Section 1224.4.4.1.1 “Airborne infection isolation exam/treatment room,” and sub-section 1224.4.4.1.1.1 “Airborne infection isolation exam/treatment anteroom” have been added to provide general requirements for such rooms common to all types of health facilities when provided.

Section 1224.4.4.2 “Specimen and blood collection facilities.” This section has been added to provide general requirements for such rooms common to all types of health facilities, when provided.

Section 1224.4.6.1 “Station outlets.” Table 1224.4.6.1 has been corrected to read “medical/surgical” in describing the patient rooms, examination or treatment rooms, airborne infection isolation or protective environment rooms, and seclusion room.

Section 1224.4.6.2 “Gas and vacuum systems.” This section has been amended to include reference to Table 1224.4.6.1.

Section 1224.4.10.2 “Minimum height with fixed ceiling equipment.” This section has been amended to include clearance requirements under suspended tracks, rails and pipes located in the traffic path for patients in beds and/or stretchers.

Section 1224.4.11 “Interior finishes.” This section has been amended to provide general requirements common to all types of health facilities and to provide consistency with the nationally recognized

standards *“Guidelines for Design and Construction of Health Care Facilities”*, 2010 edition, by the Facility Guidelines Institute with assistance from the U.S. Department of Health and Human Services. Table 1224.4.11 includes amendments to provide consistency between requirements for General Acute Care Hospitals, those for Skilled Nursing Facilities, and those for Clinics.

Section 1224.4.18 “Grab bars.” This section has been amended to clarify the placement of grab bars.

Section 1224.14 “Nursing service space.” This section has been amended to clarify where bedpan-washing fixtures may be located, and the requirement for room identification has been added.

Section 1224.15 “Surgical service space.” This section has been amended to eliminate the numbering of the single paragraph left under sub-section 1224.15.3.8, after the second paragraph had been removed under the July 2012 amendments.

Section 1224.16 “Anesthesia service space.” This section has been amended to provide clarification of the minimum clear dimensions associated with access to patients.

Section 1224.18 “Radiological/Imaging Service Space.” This section has been amended to include specific requirements for ultrasound and mammography rooms common to all health facilities, when provided.

Section 1224.19.1.1 “Handwashing fixture.” This section, under licensed pharmacy, has been amended to include locations in an anteroom or immediately outside the room where open medication is handled. An exception has also been added in reference to sterile preparation areas such as chemotherapy and intravenous solutions.

Section 1224.20 “Dietetic service space.” The section has been amended to respond to the standards provided in the *“Guidelines for Design and Construction of Health Care Facilities,”*

Section 1224.20.2.3 “Storage.” This sub-section has been amended to include a requirement of (2) days supply of frozen foods, storage space for supplies, sanitizing facilities, and separate storage for waste and recycling. A schedule has been added to provide the minimum amount of storage required for various licensed bed capacities.

Section 1224.20.2.7 “Food service carts.” This sub-section has been amended to include the requirement to eliminate cross-circulation between outgoing food carts and incoming soiled carts.

Section 1224.20.2.10 “Ware washing facilities.” This sub-section has been amended to separate ware-washing from food preparation and serving areas. The requirement for commercial-type equipment, space for receiving, scraping, sorting and stacking soiled tableware, and that convenient handwashing stations be provided has been added as well.

Section 1224.20.3 “Outside service.” This sub-section has been amended to clarify the provision of patient food service in the event that outside food service is interrupted.

Section 1224.29 “Intensive care units.” This section has been amended to provide clarification of the minimum clear dimensions associated with access to patients; to clarify the allowances provided to facilities approved under the 2001 or prior *California Building Code*; to prohibit the inclusion of a bedpan washing attachment in modular toilets; and to include new sub-section 1224.29.2.10 “Infant formula facilities” under NICU’s to provide specific requirements for these facilities, when provided.

Section 1224.33 “Emergency service.” This section has been amended to provide clarification of the minimum clear dimensions associated with access to patients, and to clarify the allowances provided to facilities approved under the 2001 or prior *California Building Code*.

Section 1224.35.4 “Speech pathology and/or audiology service space.” This section has been amended to reference current standards.

Section 1225.4.1.3 “Utility rooms.” This section, under Nursing Service Space in Section 1225 [OSHPD 2] Skilled Nursing and Intermediate-care Facilities, has been revised to provide comparable requirements to those provided in sections 1224.14.2.6 and 7 for utility rooms in nursing units in hospitals under Section 1224 [OSHPD] Hospitals.

Section 1226.1 “Scope.” This section under “Clinics” is amended to clarify that this section’s requirements also apply to outpatient clinical services of a hospital when provided in a free standing building. These OSHPD 3 Clinic regulations apply to all clinic types and are provided in a check-list format for ease of use.

Section 1226.4 “General Construction.” This section adds clinic specific amendments, and adds amendments that reference section 1224.4, General Construction. The following sub-sections have amendments:

Section 1226.4.1 “Examination and Treatment areas.” The items in this sub-section have been relocated to 1224 and apply to all healthcare facilities. The 1226 subsection numbers refer to the reference numbers in 1224. This amendment will provide clarification and coordination.

Section 1226.4.2 through 1226.4.6 These sub-sections have been amended to relocate these items to 1224 that apply to all healthcare facilities. The 1226 subsection numbers point to the reference numbers in 1224. The areas covered include: miscellaneous requirements, corridors, door and door openings, windows, and ceiling heights. This amendment will provide clarification and coordination.

Section 1226.4.7 “Interior finishes.” This sub-section has been amended to relocate these items to 1224 common to all healthcare facilities. The 1226 subsection numbers point to the reference numbers in 1224. This amendment will provide clarification and coordination.

Section 1226.4.9 “Garbage, solid waste, medical waste, and trash storage.” This sub-section has been amended to provide an alternative for the handling of medical waste and garbage in clinics.

Section 1226.4.11 “Housekeeping room.” This sub-section has been amended to refer to the 1224 requirement for all health care facilities to provide a required housekeeping room for the facility.

Section 1226.4.13 “Support areas for examination and treatment rooms.” This sub-section is amended to reorganize and consolidate space requirements for clarification in a checklist format. The term “administrative center” is added to “nurse station” for use in clinics so that the requirement is equivalent to Section 1224, requirements common to all healthcare facilities. The amended “medication station” language, and the “clean utility room” and “soiled workroom/soiled holding room” requirements are amended for consistency with the *Guidelines for Design and Construction of Health Care Facilities*. For primary care clinics, this section is amended to provide a utility sink or patient toilet room with a bedpan flushing device as an exception for the clinic sink requirement.

Section 1226.4.13.5 “Sterile and pharmaceutical supply storage.” This sub-section is amended to provide clarification and is based on the *Guidelines for Design and Construction of Health Care Facilities*.

Section 1226.4.13.6 “Sterilization facilities.” This sub-section is amended to provide clarification and is based on the *Guidelines for Design and Construction of Health Care Facilities*. When provided, these requirements are specific to clinics.

Section 1226.4.13.7 “Nourishment room.” This sub-section is amended to provide clarification and is based on the *Guidelines for Design and Construction of Health Care Facilities*. When provided, these requirements are specific to clinics.

Section 1226.4.15 “General support services and facilities.” This sub-section is amended to provide clarification and is based on the *Guidelines for Design and Construction of Health Care Facilities*. These requirements are specific to clinics.

Section 1226.4.16 “Public and administrative areas.” This sub-section is amended to clarify public area requirements for all clinics. It is based on the *Guidelines for Design and Construction of Health Care Facilities*. “Outpatient waiting room(s)” refers to the 1224 requirement for consistency.

Section 1226.4.17 “Support areas for staff.” This sub-section is added to clarify staff area requirements for all clinics. It is based on the *Guidelines for Design and Construction of Health Care Facilities*. The staff toilet requirement refers to the *California Plumbing Code*, Table 4-2.

Section 1226.5 “Outpatient Clinical Services of a Hospital.” This sectional grouping has been added to clarify previous provisions under 1226.2.1. Additional language has been added to increase consistency with *Health & Safety Code* Section 1250. Sub-sections are provided as a check-list format of references to common general construction requirements found under Section 1226.4 “General Construction” requirements for clinics. Where “Clinic” general construction requirements under Section 1226.4 refer back to the general construction requirements in Section 1224.4, intended for all health facilities, the general support areas for outpatient clinical services refer directly to the relevant sections under Section 1224.4. Outpatient services of a hospital not addressed in the provisions of Section 1226 shall continue to comply with applicable provisions of Section 1224. Common outpatient clinical service types, of a hospital in a freestanding outpatient clinical services building, have been added for convenience.

Section 1226.5.11 “Gastrointestinal endoscopy.” This section has been added as a common outpatient clinical service type. A check-list format of references to relevant requirements under Section 1224 has been provided for convenience. This proposal is intended to provide consistency and clarity.

Section 1226.5.12 “Nuclear Medicine.” This section has been added as a common outpatient clinical service type. A check-list format of references to relevant requirements under Section 1224 has been provided for convenience. This proposal is intended to provide consistency and clarity.

Section 1226.5.13 “Cancer treatment/infusion therapy service space.” This section has been added as a common outpatient clinical service type. A check-list format of references to relevant requirements under Section 1224 has been provided for convenience. This proposal is intended to provide consistency and clarity.

Section 1226.6 “Primary Care Clinics.” This section replaces Section 1226.15 and is intended for the convenience of local jurisdictions and design professionals and to clarify the existing requirements by reorganizing them into a “checklist” format. Reference is made to the “general construction” requirements in Section 1226.4 and specific requirements for primary care clinics are added as sub-sections. These amendments also clarify that outpatient clinical services of a hospital providing services equivalent to a primary care clinic shall comply with this section. The *California Mechanical Code* provides additional amendments and revisions for primary care clinics.

Section 1226.6.2.2 “Medication station.” This sub-section refers to amended section 1226.4, adding the provision of an allowance for a self-contained medicine-dispensing unit in lieu of a medicine preparation room.

Section 1226.6.2.3 & 4 “Clean utility room” & “Soiled utility room.” These sub-sections refer to amended section 1226.4, requiring separate rooms where separate areas had previously been allowed for clinics. This amendment is intended to provide consistency with other sections and with the *Guidelines for Design and Construction of Health Care Facilities*.

Section 1226.6.3.1 “Patient toilet room(s).” This sub-section refers to amended section 1226.4, adding the provision of an allowance for the patient toilet room to serve the waiting room for clinics with no more than 3 exam rooms.

Section 1226.6.5.2.1 “Medical records storage.” This sub-section refers to amended section 1226.4, providing for the storage of electronic media in lieu of paper charts.

Section 1226.7 “Primary care clinics providing abortion services.” This section replaces Section 1226.14. Clarification of treatment rooms is provided, and sub-section 1226.7.2 is added to provide requirements associated with recovery areas based on Phase II recovery presented in *Guidelines for Design and Construction of Health Care Facilities*.

Section 1226.8 “Surgical Clinics.” This section replaces Section 1226.17 and is intended to clarify the existing requirements by reorganizing them into a “checklist” format. Reference is made to the “general construction” requirements in Section 1226.4 and specific requirements for surgical clinics are added as sub-sections. This section provides consistency between the requirements for surgical service space in hospitals with those for free-standing clinical settings, while addressing specific requirements associated with clinics, as required by *Health & Safety Code* Section 1275.

Section 1226.9 “Chronic Dialysis Clinics.” This section replaces Section 1226.18 and is amended and updated to clarify existing requirements by use of a “checklist” format. Individual patient treatment areas have been clarified, and revised from 100 square feet, inclusive of aisles, to 80 square feet exclusive of circulation; the blood-borne isolation area has increased from 100 square feet to 120 square feet, and the home training area has increased from 100 square feet to 120 square feet to provide equivalence with those spaces provided in hospitals and to address accessibility requirements. These amendments also clarify that outpatient clinical services of a hospital providing services equivalent to a chronic dialysis clinic shall comply with this section, as required by *Health & Safety Code* Section 1275.

Section 1226.10 “Rehabilitation Clinics.” This section replaces Section 1226.19 and is intended to clarify the existing requirements by reorganizing them into a “checklist” format. Reference is made to the “general construction” requirements in Section 1226.4 and specific requirements for rehabilitation clinics are added as sub-sections. This section provides consistency between the requirements for rehabilitative therapy space in hospitals with those for free-standing clinical settings, while addressing specific requirements associated with clinics.

Section 1226.11 “Alternative Birthing Clinics.” This section replaces Section 1226.16 and is amended to clarify existing requirements by use of a “checklist” format, and updated to accommodate the clinical needs of the patient. This provides installation requirements consistent with the *Guidelines for Design and Construction of Health Care Facilities*. These amendments also clarify that outpatient clinical services of a hospital providing services equivalent to an alternative birthing clinic shall comply with this section.

Section 1226.11.1.1 “Birthing room.” This sub-section increases the 156 square foot area to 200 square feet as required in the *Guidelines for Design and Construction of Health Care Facilities*.

Sections 1226.11.1.6 & 7 “Window” & “Privacy.” These sub-sections provide an outside window requirement and the provision for privacy for mother and newborn as required in the *Guidelines for Design and Construction of Health Care Facilities*.

Section 1226.11.2.7 & 8 “Ice-making equipment” & “Nourishment room or area.” These sub-sections provide a requirement for ice-making equipment and for a nourishment room or area as required in *Guidelines for Design and Construction of Health Care Facilities*.

Section 1226.11.6 “Support areas for staff.” This sub-section provides requirements for staff toilets, lounge and storage for employees, as commonly required for all clinic types under section 1226.4.17, and adds a requirement for a staff changing room with a shower as required in the *Guidelines for Design and Construction of Health Care Facilities*.

Section 1226.12 “Psychology Clinics.” This section replaces Section 1226.20 and is intended to clarify the existing requirements by reorganizing them into a “checklist” format. Reference is made to the

“general construction” requirements in Section 1226.4. These amendments also clarify that outpatient clinical services of a hospital providing services equivalent to a primary care clinic shall comply with this section.

Section 1226.12.1 “Public and administrative area.” This sub-section provides requirements for public and administration area, as commonly required for all clinic types under section 1226.4.4.

Section 1604 “General Design Requirements.” This section has been amended to reflect the *International Building Code*’s inclusion of “*Ambulatory care facilities*” in Business Group “B” occupancies, resulting in the “deletion of Group I-2.1 occupancies. OSHPD’s reference to Section 308, under Risk Category IV in Table 1604.5, is no longer relevant and has been deleted.

MANDATE ON LOCAL AGENCIES OR SCHOOL DISTRICTS

The Office of Statewide Health Planning and Development has determined that the proposed regulatory action would not impose a mandate on local agencies or school districts.

OBJECTIONS OR RECOMMENDATIONS MADE REGARDING THE PROPOSED REGULATION(S).

- ***Public comments received during the 45-Day Public Comment Period from August 24, 2012 to October 8, 2012.***

Section 1224.4.4.1.1 Airborne infection isolation exam/treatment room

Commenter: Carol Corr, Kaiser Permanente

The commenter claimed not to agree with the proposed modifications as submitted and requested that this section be approved as amended. The amendment was the removal of several unnumbered requirements following the numbered requirement “6 Ventilation.” The commenter found the unnumbered text as an apparent error and that it duplicated information in the numbered items.

OSHPD Response:

The commenter is referring to language inadvertently left in an earlier draft of the Express Terms. The language requested to be removed had already been removed from the proposed amendments submitted for the 45-Day review period.

Section 1224.4.11.2.2 Wet cleaning

Commenter: Carol Corr, Kaiser Permanente

The commenter did not agree with the proposed modifications as submitted and requested that this section be held for further study. The commenter sought confirmation that quarry tile meets the intent of “homogeneous” as stated in this code revision or that the section be amended to specifically allow quarry tile in kitchens.

OSHPD Response:

The Office held a teleconference with the commenter to discuss this item. There was agreement that quarry tile is a common and appropriate floor finish for use in kitchens. After some discussion there was also agreement that the current proposed language, including the allowance of “tightly sealed joints” in a “homogeneous” floor, would not preclude the use of quarry tile in kitchens. The Office will be making no change to this section.

Section 1224.20 DIETETIC SERVICE SPACE

Commenter: Roger Richter, California Hospital Association (CHA)

The commenter agreed with the proposed modifications as submitted and requested that the entire section be approved. The commenter found that this section was needed to give direction to hospital owners as to minimum requirements and described some of the value of this provision to the industry.

OSHPD Response:

The Office held many outreach meetings with various stakeholders in the development of this provision and appreciates the validation from CHA.

Section 1224.20.2.15 Toilet room(s) and locker spaces

Commenter: Carol Corr, Kaiser Permanente

The commenter did not agree with the proposed modifications as submitted and requested this section language be held for further study based on Criteria #5. The commenter proposes the Dietetic Service employees do not require lockers in a separate room with door, and costs are added where there is no need for the function of the Dietetic Service Space.

OSHPD Response:

The dietary staff toilets and lockers should be convenient to the dietary department. The proposed language is based on the 2010 Guidelines for Design and Construction of Health Care Facilities, used as a national “model code” source.

The proposed code language modification for “enclosed separate locker area” provides language not in conflict with stipulated requirement in T22. Refer to Title 22, Section 70277 (f) (2) “Employee’s street clothing stored in the kitchen area shall be in a closed area.” In addition, the California Retail Food Code requires in Section 114256 (b), “Lockers or other suitable facilities shall be located in a designated room or area where contamination of food, equipment, utensils, linens, and single-use articles cannot occur. Section 114256.1 further requires, “lockers or other suitable facilities shall be provided and used for the orderly storage of employee clothing and other possessions.”

The Office will be making no change to this section.

Section 1224.29.1.1 Service space

Commenter: Carol Corr, Kaiser Permanente

The commenter altered the Public Comment Form to read that she did not agree with the agency “non-modification” of the section. The commenter recommended approval of an amendment to strike “or more than 12” from the current regulation limiting the number of beds in an intensive-care unit (ICU).

OSHPD Response:

The comment is in reference to existing language intended to be brought forward without modification, and not to any proposed modification. It is consequently outside the rulemaking process and not in need of a response.

Section 1224.29.1.2 Patient space

Commenter: Carol Corr, Kaiser Permanente

The commenter does not agree with the proposed modifications as submitted and recommends approval as amended. The suggested amendment strikes the requirement of the one-foot clearance from the headwall, the five-foot minimum clearance at the foot of the bed and the four-foot clearance on the non-transfer side of the bed. This leaves the requirement of a minimum of five feet on one side of the bed and a minimum of eight feet between beds in an intensive care unit (ICU).

The commenter claims the standard conflicts with, overlaps, or duplicates section 1224.32.4.2, being the current space requirements for beds in a Labor Delivery and Recovery (LDR) room, and that inconsistent but closely stated requirements lead to inconsistent interpretation. The commenter also believes the cost to the public is unreasonable, that the proposed amendment does not take into account that the length of

the bed varies by manufacturer, and that designers would need to anticipate the size of bed the facility intended to purchase or potentially oversize the room to accommodate the largest possible bed. The commenter estimated that this would add a minimum of 20 square feet, increase the structural grid, and typically 8,000 to 10,000 square feet per hospital.

OSHPD Response:

A current requirement under 1224.29.1.2 is for a minimum of 200 square feet of clear floor area in each patient space (bed) in an ICU. This requirement is proposed to be carried forward without modification. There is also a current requirement that the minimum headwall width at each bed shall be 13 feet, and it is also proposed to be carried forward without modification. If the headwall proposed in an ICU is to be the 13 feet minimum, then the depth of the clear space must be 15 feet, 4-1/2 inches. A standard hospital bed is 36 inches wide. Thus a five-foot clearance and a four-foot clearance on either side result in a total width of 12 feet. Consequently, the 13-foot requirement governs. Some bariatric beds may be as wide as 42 inches, resulting in a total width of 12 feet, 6 inches, and consequently, the headwall requirement is still the most restrictive. The five-foot clearance and the four-foot clearance on either side simply result in keeping the bed roughly centered on the headwall as opposed to allowing the bed location to be pushed to one side or the other. This provides the necessary access to each side of the bed to respond to staff and equipment needs in an intensive care setting.

A standard hospital bed is 80 inches in length, thus the one-foot head clearance and five-foot clearance at the foot of the bed total 12 feet, 8 inches. A long hospital bed might be 88 inches in length, resulting in a total depth of 13 feet, 4 inches. This is significantly less than the 15 feet 4-1/2 inches required if the 13 foot minimum headwall were to be used. Consequently, the one-foot head clearance and the five-foot clearance at the foot of the bed are easily accommodated in order to provide the necessary access for an intensive care setting.

If the 200 square foot minimum clear area were to be divided by a 13 foot, 4 inch depth, accommodating a very long bed, the resulting width would need to be 15 feet, being two feet wider than the headwall requirement. It appears that the two current requirements easily accommodate the proposed amendments without any increase in area. The commenter's estimate of an additional 20 square feet is not supported by the mathematics.

Section 1224.29.1.2 Express Terms provide the same language for the ICU clearances as that provided in the 2010 *Guidelines for Design and Construction of Health Care Facilities*, used as the "model code" source. Current CBC Section 1224.32.4.2 requirements for a minimum clear dimension of 13 feet and the requirement for space for infant stabilization and resuscitation for Labor Delivery and Recovery (LDR) rooms are also taken from the *Guidelines*. ICUs and LDR rooms have very different needs and, consequently, the requirements of H&S §70499 and §70553 are quite different. An effort to make Sections 1224.29.1.2 and 1224.32.4.2 parallel would not respond to the very different needs and requirements for an ICU and for an LDR room.

The Office finds that the proposed amendments to provide minimum clearances at the head, sides, and foot of the bed in an ICU do not add any additional area or headwall width minimums currently required; these clearances are also necessary to provide the staff and equipment access required in an intensive care setting. The Office will be making no change to this section.

Section 1224.29.1.4 Modular toilet

Commenter: Carol Corr, Kaiser Permanente

The commenter suggested an amendment to the section and recommended disapproval based on Criteria #8. The commenter suggested removing the proposed change in language. The commenter believes the bedpan washing attachment is a standard feature on modular toilets and a prohibition on its use at the modular toilet would require hospitals to install a separate more costly bedpan washing hose. The other option given was for staff to transport dirty bedpans through the corridors to a location for cleaning.

OSHPD Response:

The bedpan washing attachment at a modular toilet in a patient space or private room involves an issue regarding standard infection prevention and control practices. The proposed language is based on the 2010 Guidelines for Design and Construction of Health Care Facilities, used as a national “model code” source. In Section 2.2-2.6.2.6, the patient care room must have “direct access to an enclosed toilet room or soiled utility room for disposal of bodily waste.” Also, the Guidelines states “a toilet with bedpan washer or a flushing clinical sink” will be provided. If 1) the bodily waste is disposed of in the modular toilet, 2) the toilet is closed and then flushed, then, 3) the bedpan is taken to the appropriate location for cleaning, this procedure may be proposed in a program flex to Licensing for approval. Title 22 states in Section 70817 *Provisions for Emptying Bedpans*: “Bedpans shall be emptied and cleaned in utility rooms or in toilets adjoining patients’ rooms when such toilets are equipped with flushing attachments and vacuum breakers.” OSHPD proposed code changes in Title 24 rulemaking must fit together with the language in Title 22.

The Office will maintain the proposed modification to code language.

Section 1226.2 Application

Commenter: Essie Santana Tuttle, La Clinica de La Raza, Inc. & Ginger Smith, California Primary Care Association

These commenters did not agree with the proposed modifications as submitted and recommended approval as amended, based on Point #5. Ginger Smith recommended limiting the application of Section 1226 [OSHPD 3] Clinics in the conversion of space to clinical use within existing buildings to only what had previously been “non-medical” existing space. Essie Tuttle recommended limiting the application of Section 1226 to only “new construction,” and to allow alterations and renovations to be exempt from compliance with these standards.

Commenter Smith stated that many community clinics in California are working in low-income, underserved communities, and that these clinics often lease medical office space previously utilized by private physicians, and that renovations required for compliance with Section 1226 is not cost-effective and could cost a clinic hundreds of thousands of dollars. The commenter reasoned that when costs for community clinics increase, the cost to the public also increases.

OSHPD Response:

The proposed building standard is intended to clarify the existing language “alteration or repairs to existing buildings” as including “*conversion of space to a clinic use within existing buildings, subject to licensure by Licensing and Certification, California Department of Public Health.*” This is consistent with current *California Building Code* (CBC) Section 101.2 defining the scope of the *California Building Code* in the application of provisions of the code to construction, alteration, repair, “use and occupancy” of every building. The 2012 *International Building Code* (IBC) model code has retained these provisions.

Primary Care Clinics licensed under Health and Safety Code (H&SC) §1200 are required to be in compliance with Title 24, California Administrative Code and provisions approved by the Office of Statewide Health Planning and Development (OSHPD) per *California Code of Regulations* (CCR) Title 22, Division 5, §75060. H&SC §1226 (b) requires the “*Office of Statewide Health Planning and Development, in consultation with the Community Clinics Advisory Committee, shall prescribe minimum construction standards of adequacy and safety for the physical plant of clinics as found in the California Building Standards Code.*” The commenter’s suggestion of allowing private physician’s offices, as previous “medical” space, to be exempt from OSHPD 3 requirements as provided in CBC Section 1226, when converting space to become a new Primary Care Clinic licensed under H&SC §1200, would be in direct violation of the Health & Safety Code, Title 22, and the model code used for the *California Building Code*.

The Office is sensitive to the need to keep health care affordable in California with particular emphasis on small community primary-care clinics. Other sections in the proposed Express Terms introduce several modifications to existing regulations that result in cost savings in the construction of these facilities, while there are no proposed modifications that would result in any increase in cost for primary-care clinics. The cost savings are quantified in the Economic and Fiscal Impact Statement of this proposal. A summary of these cost savings is as follows:

- CBC Section 1226.4.9.3 will allow the provision of waste holding areas for primary-care clinics in lieu of the current waste collection and washing areas.
- CBC Section 1226.4.14 introduces the provision of a combined patient/public restroom for small primary-care clinics in lieu of the separate patient and public restrooms currently required.
- CBC Section 1226.4.16.2 will allow for the use of electronic media storage in primary-care clinics in lieu of the current requirement for a medical records storage room.

The intent is to provide as much relief as possible to small primary-care clinics while still meeting the minimum standards of Chapter 3.3 Specific Requirements for Small Primary Care (Neighborhood) Outpatient Facilities as presented in the *Guidelines for Design and Construction of Health Care Facilities* published by the Facility Guidelines Institute with assistance from the US Department of Health and Human Services. These guidelines are recognized as the national standard for health care facilities in the United States and serve as the model code for many states.

The California Department of Public Health (CDPH) makes a special allowance for a primary-care clinic that proposes to operate its clinic out of an existing facility (such as a private doctor's office) that does not satisfy all of the applicable building requirements, other than fire and life safety requirements, if the applicant complies with applicable building requirements where possible and feasible, and the applicant commits to a plan to make the necessary modifications to bring the facility into substantial conformance with the applicable building codes over a three-year period. The Office will be making no change to this section.

Section 1226.4.1.3 Examination or treatment room

Commenter: Roger Richter, California Hospital Association (CHA)

The commenter agreed with the proposed modifications as submitted and requested that the entire section be approved. The commenter found that this section appropriately linked to Section 1224.4.4.1, and that the 80 square-foot minimum was necessary to accommodate the patient, the patient's companion, a nurse and the physician. The commenter cited the national *Guidelines for Design and Construction of Health Care Facilities* as requiring the same minimum area for exam rooms in clinics such as those licensed under Title 22.

OSHPD Response:

The Office held many outreach meetings with various stakeholders in the development of this provision and appreciates the validation from CHA.

Section 1226.4.1.3 Examination or treatment room

Commenter: Essie Santana Tuttle, La Clinica de La Raza, Inc. & Ginger Smith, California Primary Care Association

These commenters did not agree with the proposed modifications as submitted and recommended approval as amended, based on Point #5. Each commenter recommended an exception to allow facilities built prior to 2001 to provide exam rooms with a 70 square-foot minimum area and at least one that was wheelchair accessible or 80 square feet. Essie Tuttle also included a 10% minimum of the number of exam rooms to be accessible.

OSHPD Response:

Proposed Section 1226.4.1.3 refers the requirements for examination or treatment rooms in clinics to those currently required in Section 1224.4.4 (renumbered 1224.4.4.1). The use and needs for an exam room are the same whether in a clinic, hospital, or skilled nursing facility. The 80 square feet is the minimum area needed to respond to the functional requirements of an examination/treatment room (refer to the comment from Roger Richter, representing the California Hospital Association, listed above). This minimum area is also required to provide access to those with mobility impairments. California accessibility requirements require that access be provided to all exam and treatment rooms; not just a portion. This section cannot be used to provide an exemption to the requirements of CBC Chapter 11B. However, it should also be noted that the provisions of Section 1226.4.1.3 are intended for new

construction and alteration projects, and are not applied retroactively to existing clinics with non-compliant exam or treatment rooms that are not otherwise being altered. Current CBC Section 1134B delineates if and when accessibility compliance to such areas is required. These provisions are also proposed to be carried forward by the Division of the State Architect (DSA) as new CBC Section 11B-202.4. H&S §18930(a)(1) requires that proposed building standards shall not conflict with other building standards.

Refer to the Office's more comprehensive response to related Section 1226.6.1.1. The Office will be making no change to this section.

Section 1226.4.13.4 Soiled workroom or soiled holding room

Commenter: Ginger Smith, California Primary Care Association (CPCA)

The commenter did not agree with the proposed modifications as submitted and recommended approval as amended based on Point #3. The suggested amendment was for an exception to the requirement of work counter and handwashing fixture if the room is used only for holding prior to removal and no processing of the waste occurs on the premises; and suggested an additional exception from any requirement for a soiled workroom if all waste is stored in container(s) outside the clinic. The commenter explained that in some health centers biological waste (red bags) were stored in a cabinet for a few days prior to retrieval, while in others the red bags were deposited directly into containers outside the building for retrieval by the waste collection company. Consequently, she believed that neither a soiled workroom nor a soiled holding room was necessary.

OSHPD Response:

The Office held many outreach meetings with various stakeholders, including CPCA, in the development of this provision. Infection control remains a high priority throughout health care facility development in the State of California. The Association for Professionals in Infection Control and Epidemiology (APIC) published *Infection Control in Ambulatory Care* in 2004 due to "an increasing number of patients with a variety of illnesses cared for in ambulatory care settings. These patients are often immunocompromised due to underlying illness or treatment practices. In addition, many diagnostic and treatment modalities, including invasive and surgical procedures, are now performed in ambulatory settings. The combination of immunocompromised patients and complexity of care in ambulatory settings results in a need to focus on prevention of infection."

The authors state "Infectious diseases account for 20 to 30% of physician office visits... There have been multiple outbreaks of measles, tuberculosis, and other infectious diseases traced to physician offices or clinics. Most of these outbreaks were associated with noncompliance with [infection control] IC procedures. Medical conditions that were once managed in the acute care hospital are now being treated in ambulatory care settings. These conditions require infusion therapy, dialysis, endoscopy, and other invasive procedures. In addition, an increasing number of surgical procedures have shifted from inpatient to ambulatory settings." The authors cite "Standard infection prevention and control practices are the most effective means for reducing the risk of infection in the ambulatory setting. Handwashing remains the most important intervention for the prevention of infection in any healthcare setting... Effective reprocessing of patient care equipment and devices is one of the most challenging aspects of infection prevention and control in ambulatory care... Standard practices are also cost-effective, prolong the life of instruments, provide adequate documentation for regulatory agencies or managed care surveyors, provide for consistent reprocessing after each patient use, and can be flexible enough to accommodate the addition of new instruments."

The authors conclude that "sterilization must be used for items that come into contact with the vascular system or with normally sterile tissue and body cavities. In the outpatient setting, items may be purchased sterile (and disposed of after use, e.g. hypodermics needles, syringes), sterilized by a third party, or sterilized on site... reprocessing activities should occur in a separate soiled utility room."

The authors state "Regulated medical (infectious) waste and regular trash must be separated for disposal... approved sharps containers must be located at the point of use; they should be placed in all examination, treatment, and procedure rooms, phlebotomy stations and utility rooms..." They continue:

“Red bags, biohazard buckets, or other containers... should be placed judiciously. It is often practical and sufficient to place one container for regulated waste in the lab area or utility room and one in each procedure or treatment room that generates regulated waste on a regular basis.” They conclude that “environmental services staff members should promptly remove trash and medical waste, and should maintain an environment that enhances patient care.”

California Health and Safety Code (H&S) §118275 requires that “medical waste shall be contained separately from other wastes at the point of origin in the producing facility. Sharps containers may be placed in biohazard bags or in containers with biohazard bags. Biohazard waste... shall be placed in a red biohazard bag conspicuously labeled with the words Biohazardous Waste or with the international biohazard symbol and the word BIOHAZARD.” H&S §118280 requires “The bags shall be tied to prevent leakage or expulsion of contents during all future storage, handling, or transport. Biohazardous waste... shall be bagged... and placed for storage, handling, or transport in a rigid container which may be disposable, reusable, or recyclable... Biohazardous waste shall not be removed from the biohazard bag until treatment... is completed.” H&S §118307 allows for an interim storage area. “Medical waste that is stored in an area prior to transfer to the designated accumulation area, as defined in Section 118310, shall be stored in an area that is either locked or under direct supervision or surveillance. Intermediate storage areas shall be marked with the international biohazardous symbol or the signage described in Section 118310.”

H&S §118310 provides for a designated accumulation area that is “used for the storage of medical waste containers prior to transportation or treatment shall be secured so as to deny access to unauthorized persons and shall be marked with warning signs on, or adjacent to, the exterior of entry doors, gates, or lids. The storage area may be secured by use of locks on entry doors, gates, or receptacle lids.”

Proposed CBC Section 1226.4.9 provides the requirements for a medical waste storage enclosure, including the capability for container washing. As an alternative Section 1226.4.9.3 allows for the provision of a waste holding room with 100% exhaust air. Either of these approaches would serve as the “designated accumulation area” required by H&S. CBC Section 1226.4.13.4 provides the requirements for the soiled workroom, including a work counter, clinical sink and a handwashing fixture. This section also provides the same requirements for a soiled holding room. This would serve as the “interim storage area” as described in H&S §118307.

The provisions under Section 1226.4 are common to all clinics and outpatient clinical services under a hospital license, including the various specialty clinics. The nature of a soiled workroom, or soiled utility room in these settings, is to receive soiled materials, and instruments, and allow for the eventual disposal of soiled materials, and the appropriate cleaning and sterilization of soiled instruments. The clinic types required to have a soiled workroom, or soiled holding room, generate regulated medical waste and shall meet the requirements of this section. The requirement for a counter and a handwashing fixture is a necessary part of infection control associated with the handling of soiled material and/or instruments. The Office will be making no change to this section.

Section 1226.4.13.6 Sterilization facilities

Commenter: Carol Corr, Kaiser Permanente

The commenter suggested amendments to the section and recommended approval as amended based on Criteria #1. The commenter suggests the amendment duplicates the sterile storage requirements and Sterilizing facilities requirements overlap and conflict with the individual requirements. The commenter suggests deleting requirements for storage and sterilizing and equipment disinfection space.

OSHPD Response: Section 1226.4.13.6 Sterilization facilities are optional in a clinic. The requirement begins with, “When provided,” thus, the requirements that follow in this section are required only if an on-site sterilization facility is provided at the licensed clinic location. Section 1226.4.13.5 Sterile and pharmaceutical supply storage is a distinct requirement whether a sterilization facility is provided in the

clinic or not. This type of storage is distinct from general storage. In Section 1226.4.13.6.2 (#3), the requirement is for space for special equipment to do the action of sterilizing, while (#4) requires separate storage for sterile and unsterile supplies. These two requirements address separate functions, thus do not duplicate each other.

The requirements for Sterilization facilities were taken from the *Guidelines for Design and Construction of Health Care Facilities* published by the Facility Guidelines Institute with assistance from the US Department of Health and Human Services. These guidelines are recognized as the national standard for health care facilities in the United States and serve as the model code for many states.

The Office will be making no change to this section

Section 1226.4.14 Support areas for patients

Commenter: Essie Santana Tuttle, La Clinica de La Raza, Inc.

The commenter did not agree with the proposed modifications as submitted and recommended language similar to the agency proposed modifications. The commenter's amendment required "that combined visitor and patient toilets be allowed for smaller clinics with three or fewer exam rooms" to allow for more patient service space and to avoid unnecessary costs for smaller clinics.

OSHPD Response:

The proposed Section 1226.4.14.1 Exception provides for primary care clinics that "contain no more than three examination and/or treatment rooms" to permit a patient toilet room "to serve the outpatient waiting room." This essentially combines the patient toilet room with the visitor toilet room into a single toilet room. The commenter's amended language isn't necessary to achieve the stated goal. The proposed language is taken from the 2010 national *Guidelines for Design and Construction of Health Care Facilities*, used as a "model code" source. The commenter's language offers no significant advantage over model code language. The Office will be making no change to this section.

Section 1226.4.14 Support areas for patients

Commenter: Ginger Smith, California Primary Care Association

The commenter did not agree with the proposed modifications as submitted and recommended approval as amended, based on Points #4 and #5, and recommended extending the provision to primary care clinics with no more than six examination and/or treatment rooms. The commenter stated that plumbing is relatively expensive, and that the number of toilets should be limited to what would be required based upon occupancy. The commenter speculated that a small clinic with one physician and four exam rooms could be required to have five toilet rooms, requiring unnecessary additional costs and limiting the space that can be used for patient care. The commenter also cites the National Association of Community Health Centers definition of small clinic as those with less than 7,110 patients, adds that the standard panel for a provider is 1,500 patients, and each (full time equivalent) FTE provider needs two exam rooms, and deduces that a six exam-room clinic meets the definition of a small clinic.

OSHPD Response:

The language in the Express Terms is based on Section 3.3-3.2.6.7 Toilet rooms under Specific Requirements for Small Primary Care (Neighborhood) Outpatient Facilities of the *Guidelines for Design and Construction of Health Care Facilities*, 2010 edition, a nationally recognized standard. This is the source of the language regarding "small clinic" and the definition of that term as used in their regulation. Mixing terms and definitions results in unintended difficulties in application.

The provision of sanitary facilities is currently regulated by code requirements in the California Plumbing Code (CPC). The total occupancy of a building is governed by Chapter 10 of the California Building Code. CBC Table 1004.1.1 cites both "outpatient areas" and "business areas" as 100 gross square feet per occupant. CPC Chapter 4 Table A provides an occupant load factor for both "health care facilities" and for "offices" as 200 square feet per occupant to be used for the "public" and for "employees" when determining the minimum plumbing fixture requirement. This minimum number of fixtures is to be based on 50% male and 50% female. CPC Table 4-1 is model code language and requires a minimum of 1

water closet for 1-100 and no urinals for less than 25 male “public” occupants, 1 water closet for 1-25 female “public” occupants, 1 water closet for 1-15 and no urinals for less than 10 male “employees”, and 1 water closet for 1-15 female employees. This might suggest a minimum of four toilet facilities for any professional office, however there are exceptions that may be used as noted below.

CPC Table 4-3 addresses the minimum fixtures to be provided for employees in the State of California. Office buildings (and similar establishments) require 1 water closet for 1-15 male employees, and 1 water closet for 1-15 female employees. Urinals may be provided to replace up to one third of the required water closets on a one-to-one basis, but none are required. This is similar then to the model code for small buildings. However, footnote 7 of CPC Table 4-3 allows the use of a unisex facility for less than five employees (where employee count is rounded up to a whole person). Thus for a clinic or doctor’s office that is equal to, or less than, 800 square feet, results in 4 employees (presumably one FTE provider and three supporting staff members) and only requires a single unisex toilet room for employee use. CPC Section 412.3 (2) provides that where the total occupancy serves 10 or fewer people (employees and public) a single public toilet shall be permitted to be used by both sexes. Consequently, small offices could be required to have only two toilet rooms (one for the public and one for staff).

Model code does have an additional exception that will allow a “business” occupancy with a floor area of 1,500 square feet or less, to provide a single toilet room to serve “customers” and “employees” of both sexes, however medical facilities serve “patients”, not “customers”, and CPC Section 412.4 states additional fixtures may be required for other activities. The required segregation of staff toilets from public and patient toilets in medical facilities is necessary for infection control. The size of the facility does not influence this requirement. Consequently, Section 412.5, which could result in only one toilet room shared by customers and employees in a business/mercantile occupancy, is not available for clinics.

The revised language from the commenter suggests a threshold of three FTE providers with six or fewer exam rooms for a patient toilet allowed to serve the waiting room. Three FTEs and six exam rooms would result in a larger clinic (approximately 2,500 to 3,000 square feet) with 25 to 30 occupants per CBC Chapter 10. While the provision of a single patient (unisex) toilet might serve the six exam rooms and accommodate specimen collection, the “public” toilets remain at a minimum of one for each sex (required to be accessible from the waiting area), per current CPC, model code, and as retained in the proposed language for the CPC.

The staff toilet requirements remain as currently required in CPC Table 4-1 (model code) and CPC Table 4-3 (based on California labor laws). Three FTE providers, plus nurses, and administrative staff would result in at least 12 employees, at a rate of three staff members per FTE. This exceeds the four staff employees allowed under the exception provided in CPC Table 4-3 (footnote 7). Consequently, a male staff toilet and a female staff toilet would be required. Thus a clinic with three FTE providers and six exam rooms, as described by the commenter, would likely result in two public (one male and one female) and two staff (one male and one female) toilet rooms due to existing CPC requirements. The commenter’s suggested amendment to six exam rooms will not achieve the intended goal.

Patient toilets are allowed to be “unisex.” A small primary-care clinic with three or fewer exam rooms could be 1,000 square feet or less, resulting in 10 or less total occupants. Therefore unisex toilets could be provided for the public per CPC Section 412.3 exception (2). Consequently, the proposed Express Terms will provide an allowance to take advantage of the existing CPC exception and combine a shared use between patients and the public.

While the segregation of “public” from “patient” toilet rooms is currently required by CPC Section 412.3.1, the Express Terms propose an allowance for small facilities, with three or fewer exam rooms, where the occupant load could drop below 10, and the model code exception could be used. The “public” toilet rooms could then be unisex, and combined with patient toilet rooms that are unisex by nature. Once the occupant load exceeds 10 however, the model code exception no longer applies, and the public toilet rooms are required to be separate sex as per model code. OSHPD does not have the authority to dismiss these requirements.

It is important to note that there are no new costs associated with the amendment. The exception, as currently proposed, will actually result in an initial cost savings of roughly \$28,356 per facility plus an indeterminable savings in monthly rent over existing requirements. The Office is sensitive to the need to keep health care affordable in California with particular emphasis on small community primary-care clinics. The proposed Express Terms introduce a modification of existing regulations that result in cost

savings in the construction of these facilities. These cost savings are quantified in the Economic and Fiscal Impact Statement of this proposal.

The commenter's suggested amendment alters the language provided by the *Guidelines for Design and Construction of Health Care Facilities*, used as a model code source, defines a term differently than the model code source, results in conflict with other building standards, and will not provide any relief beyond the proposed language due to other current provisions of the CBSC. The Office will be making no change to this section.

Section 1226.5.5.1.4 Handwashing fixtures. (for Radiological/Imaging service space)

Commenter: Carol Corr, Kaiser Permanente

The commenter suggested amendments to the section and recommended approval as amended based on Criteria #1. The commenter suggested parenthesis around the letter "s" in fixtures to allow for a minimum of one.

OSHPD Response: The parenthesis will be placed around the letter "s".

Section 1226.5.5.1.6 Medication station

Commenter: Carol Corr, Kaiser Permanente

The commenter suggested amendments to the section and recommended approval as amended based on Criteria #1. The commenter is concerned the requirement for locked storage of medications and drugs in the radiological/imaging service space is unnecessary at times. Thus, the commenter believes the qualifying phrase "when provided" should be used.

OSHPD Response: The proposed requirement is based on both the 2010 Guidelines for Design and Construction of Health Care Facilities, used as a national "model code", in 2.2-3.4.6.7 Medication storage- Provision shall be made for locked storage of medications and drugs, and the 2010 CA Building code in the Radiological/Imaging Service Space under Section 1224.18.6.5 Locked Storage-- Provision shall be made for locked storage of medications and drugs.

The Office will be making no change to this section.

Section 1226.5.6 X-ray examination services

Commenter: Carol Corr, Kaiser Permanente

The commenter suggested amendments to the section and recommended approval as amended based on Criteria #1. The commenter is concerned the requirement for an office or other suitable area for viewing and reporting a radiographic examination should have an exception for off-site reading or by a reading service.

OSHPD Response: The proposed requirement is based on both the 2010 Guidelines for Design and construction of Health Care Facilities, used as a national "model code" source, in 2.2-3.4.6.2 Offices for radiologist(s) and assistant(s)-- Offices shall include provisions for viewing, individual consultation, and charting of film, and the 2010 CA Building Code in the Radiological/Imaging Service Space under Section 1224.18.1(4)-- An office or other suitable area for viewing and reporting radiographic examination. This space is common to the diagnostic imaging department and is a minimum requirement.

The Office will be making no change to this section.

Section 1226.5.11 Gastrointestinal endoscopy

Commenter: Carol Corr, Kaiser Permanente

The commenter did not agree with the proposed modifications as submitted and requested this section language be held for further study based on Criteria #1 and #4. The commenter suggested the language below the initial passage was unnecessary and duplicative. In addition, the commenter understood the proposed code language added requirements beyond those in Section 1224.39 for inpatient endoscopy services.

OSHPD Response: The stakeholders meetings for clinics generated suggestions for the format of clinic code language. One of which was to provide the clinic code in checklist format. Thus, a check-list format of references to relevant requirements under Section 1224 has been provided for convenience of application by local building officials. The proposal is intended to provide consistency and clarity. The “pointers” cover the basic requirements including utility rooms, medication station, storage, etc. that are requirements for both inpatient and outpatient services. The intent is to remind the clinic project team of the spaces required to provide a code compliant service space. The Office will be making no change to this section.

Section 1226.5.11.6.5 Gastrointestinal endoscopy Anesthesia workroom

Commenter: Carol Corr, Kaiser Permanente

The commenter suggested amendments to the section and recommended approval as amended based on Criteria #1. The commenter is concerned the Anesthesia Workroom requirement is different for the Gastrointestinal endoscopy service based in Outpatient Clinical Services of a Hospital, as opposed to, endoscopy procedure rooms in an outpatient hospital surgery department.

OSHPD Response: The Anesthesia Workroom is required for both situations. In the Surgical Services Space, where the endoscopic procedure rooms are located, there is a requirement for an Anesthesia Workroom. Thus, the equivalent requirement for the gastrointestinal endoscopy procedure rooms in Outpatient Clinical Services of a Hospital shall provide an Anesthesia Workroom for this service.

The proposed requirement is based on both the 2010 Guidelines for Design and Construction of Health Care Facilities, used as a national “model code” source, and 2010 CB Building Code under 1224 outpatient current requirements. The Office will be making no change to this section.

Section 1226.5.11.6.7 Gastrointestinal endoscopy Staff clothing change areas

Commenter: Carol Corr, Kaiser Permanente

The commenter did not agree with the proposed language as submitted and requested this specific section be held for further study based on Criteria #1. The commenter understood the proposed code language added requirements beyond those in Section 1224.39 for inpatient endoscopy services.

OSHPD Response:

The Staff clothing change areas are required for both Outpatient Clinical Services of a Hospital and an endoscopy procedure room in a hospital surgery department. The requirement is existing language for an endoscopy procedure room in a hospital surgery department. It is appropriate that the same requirement is provided for staff convenience and privacy. The proposed language is based on the 2010 Guidelines for Design and Construction of Health Care Facilities, used as a national “model code” source. (Refer to 3.9-3.7.1 Staff Clothing Change Areas) The Office will be making no change to this section.

Section 1226.5.11.7.1 Gastrointestinal endoscopy Outpatient change areas

Commenter: Carol Corr, Kaiser Permanente

The commenter suggested deleting the proposed language and recommended approval as amended based on Criteria #1. The KP universal way for patients to change is in prep. and recovery cubicles. The patients are kept track of easier and reduce patient movement. In addition, the commenter believes the proposed code language adds requirements beyond those in Section 1224.39 for inpatient endoscopy services.

OSHPD Response:

The commenter suggested the Kaiser procedure for patients to change in the preparation and recovery cubicles is more efficient for the KP universal way, than separate patient changing rooms. Because changing areas are common use areas CBC Chapter 11B requires they be 100% accessible. That means the preparation and recovery cubicles must have an accessible bench, clothing hooks, lockers to secure belongings, appropriate accessible dimensions on either side of the bed/gurney and the full length of the bed/gurney in the prep/recovery cubicle.

The proposed language for outpatient change areas is based on the 2010 Guidelines for Design and Construction of Health Care Facilities, used as a national “model code” source. (Refer to 3.9-3.8.1 Patient Change Areas) In addition, there is existing language in CBC Section 1226.17.9 Outpatient change area—A separate space shall be provided where outpatients change from street clothing and are prepared for surgery. This would include provisions for clothing storage, toilet room(s), sink space for clothing change and gowning area.

The patient changing area requirement acknowledges the provision for patient privacy per this code.

The Office will be making no change to this section.

Section 1226.6.1.1 Examination room(s)

Commenter: Lilly Spitz, Planned Parenthood Affiliates of California (PPAC)

The commenter did not agree with the proposed modifications as submitted and recommends that this provision require further study on the grounds of Points #3 and #4. The commenter also offered a compromise to approve the section as amended. The commenter’s amendment would modify CBC Section 1224.4.4.1 “Examination or treatment room” under Section 1224 “Hospitals”. The modification reduces the current requirement of 80 square feet minimum clear area to a new requirement of 70 square feet and adds that, at a minimum, 10% of the examination or treatment rooms shall have a minimum of 80 square feet.

The commenter stated that the current requirements under CBC Section 1226 Clinics were adopted more than 25 years ago and established 70 square feet as a minimum area for examination rooms. The commenter also stated that over these 25+ years, PPAC was not aware of a single complaint from a patient, family member or health care professional with physical challenges requiring a wheelchair, regarding the inability to access their clinic’s examination or treatment rooms.

The commenter believes the current CBC Section 1109B.6 requirement that medical diagnostic rooms “shall be made accessible,” is vague and without specific measurements. The commenter also believes that the clarified requirement to be without “evidentiary basis.” The commenter stated that if a clinic were to move into a former primary care clinic, improvements would force each of the existing exam rooms to be expanded by 10 square feet resulting in a significant financial burden. The commenter found that compliance with the requirements would “certainly cause primary care clinics to plan exclusively for new construction rather than attempting to move into a building in an underserved area that is desperate for primary care services.” Consequently, the commenter believes the clarification intended by the proposed Section 1226.6.1.1 should undergo further study to determine if an 80 square-foot area was truly the minimum necessary to provide access by physically challenged people utilizing wheelchairs.

OSHPD Response:

Proposed Section 1226.6.1.1 links the requirements of examination rooms for Primary Care Clinics to existing Section 1224.4.4 (renumbered 1224.4.4.1) which currently requires the minimum size of an examination or treatment room for use in any medical facility, unless specified elsewhere, as having “a clear floor area of 80 square feet (7.4m²), the least dimension which shall be 8 feet (2438mm). The room shall contain a handwashing fixture.” The commenter suggests language to reduce the current requirement of 80 square feet to only 70 square feet in Section 1224.4.4.1. This would be a reduction in the requirements for exam room size throughout all medical facilities, including General Acute Care Hospitals and Skilled Nursing Facilities, to a size that will not accommodate accessibility nor provide sufficient functional area to adequately perform physical examinations or even minor treatment procedures. The commenter also suggests that a minimum of “10% of the examination or treatment rooms shall have a minimum clear floor area of 80 square feet” be added to Section 1224.4.4.1.

The commenter, representing Planned Parenthood Affiliates of California (PPAC), states that PPAC is not aware of a single complaint regarding the inability to access their examination or treatment rooms. It is important to note, however, that the commenter’s statement does not mean that there are not any accessibility difficulties or that 70 square feet is sufficient. The commenter did not claim that their exam rooms are only 70 square feet in size, but only that 70 square feet was cited as a minimum size for Primary Care Clinics over 25 years ago.

Regarding complaints and reporting: Elizabeth Pendo, Professor of Law, Saint Louis University School of Law, prepared and published a paper in 2009 entitled “*Disability, Equipment Barriers, and Women’s Health: Using the ADA to Provide Meaningful Access.*” The paper discusses barriers to access to the delivery of women’s reproductive health care. In Part III, Section B, she cites “a survey conducted by CROWD [Center for Research on Women with Disabilities] in 1995 found that surveyed physicians saw fewer than ten women with disabilities over the course of a year [from Grabois & Nosek]. They knew that women with disabilities were ‘out there, but they did not know where they were going’ to get basic women’s health and reproductive care. Interestingly, the ‘physicians reported that they knew of no problems of access to the buildings in which they treated their patients, while investigators were aware of accessibility complaints by women with physical disabilities who tried to use those same buildings.’”

The commenter’s statement should be taken in the context of these studies. There is no statistical information provided by the commenter relative to the number and/or percentage of mobility impaired patients seen in Planned Parenthood facilities having only 70 square foot exam and treatment rooms (or if they have such rooms). However, given the Grabois & Nosek study, an unawareness of “complaints” against such facilities does not necessarily mean an absence of barriers to accessibility. Mobility impaired patients may simply be going elsewhere, they may have difficulties but not have made any “complaints”, or they may have made complaints but the commenter and/or those that were contacted may be unaware of them.

The commenter states that the Office has not provided any evidence that the current regulation is a barrier to access for wheelchair-bound individuals or that there is a need for the minimum 80 square foot space requirement. Accessibility includes appropriate maneuvering area to open and pass through the doorway, the ability to turn around within the room, the ability of patients to get onto and off of the exam table, and the ability of disabled staff to access the patient and perform their duties during an examination. This is accomplished by a 60-inch by 60-inch area at the door, including an 18-inch clearance at the door strike as required by the accessibility standards found in CBC Chapter 11B and in the ADA. Pushing an exam table up against the opposite wall requires (with very little tolerance) an additional 36 inches. This results in the 8-foot minimum dimension in width. With the exam table and physician’s stool/clear space along one wall; the 60 inch door clearance, 24 inches guest chair space, and a 36 inch long counter/cabinet with the required accessible handwashing fixture along the opposite wall results in a minimum of 10 feet in depth. Consequently, 80 square feet (8 feet x10 feet) is truly the minimum size for an exam room. Additional clear area is likely necessary to adequately conduct a physical examination in some cases. The code only provides the minimum requirements.

The U.S. Department of Justice and the U.S. Department of Health and Human Services jointly published *Access to Medical Care for Individuals with Mobility Disabilities* in 2010 as a technical assistance publication to provide guidance on the requirements of ADA in medical settings with respect to people with mobility disabilities. Part 3 of that document describes the features required to allow the patient to enter the examination room, move around in the room, and utilize the accessible equipment provided. The features are defined as “an accessible route to and through the room; an entry door with adequate clear width, maneuvering clearance, and accessible hardware; appropriate models and placement of accessible examination equipment; and adequate clear floor space inside the room for side transfers and use of lift equipment.” The document states that “*new and altered examination rooms must meet requirements of the ADA Standards for Accessible Design. Accessible examination rooms may need additional floor space to accommodate transfers and for certain equipment, such as a floor lift.*” The publication includes an illustration of an accessible examination room. The layout places the 60-inch maneuvering area at the foot of the exam table resulting in over an 11-foot depth. They also show a 24-inch deep cabinet, a 36-inch route to side transfer clear space, a 30-inch wide table, and 24 inches between the exam table and the wall to allow “*staff to assist with patient transfers and positioning*” and noted that “*when additional space is provided, transfers may be made from both sides.*” This results in just under a 10-foot width. While they do not specify a 10-foot by 11-foot, or 110 square foot minimum size, they do refer the design professional to various requirements contained in the ADA Standards for Accessible Design to use when configuring site specific exam rooms. California Accessibility Standards take this same approach.

The commenter cites potential adaptive re-use of existing “medical” space, when licensed as a new clinic and expresses concern that these existing facilities would only have 70 square foot exam rooms, and thus the burden to increase the size of each would be costly. While CBC Section 1226.15.1 may have allowed 70 square feet, if the clinic was built within the last 35 years, the exam rooms would have needed to comply with California’s accessibility standards and thus resulted in the size described in the paragraph above. Even if the existing space did have 70 square foot exam rooms, adaptive re-use is not exempt from compliance with CBC Chapter 11B, regardless of the language in Section 1224.4.4.1.

All exam rooms are considered “common use areas” as currently defined in CBC Section 1102B, as opposed to “specific work stations” defined in CBC Section 1123B. Additionally, all diagnostic and treatment areas are required to be made accessible per current CBC Section 1109B.6. Since all exam rooms are currently required to be accessible, and the minimum size continues to be 80 square feet, there is no measurable change when complying with all pertinent requirements and there is no change in cost that would be borne by either the public or the private sector.

In addition to accessibility issues, a smaller exam room will not meet the necessary functional requirements associated with rooms used for examinations. The following national standards were reviewed for comparison to the requirements for compliance in California:

- The 2010 *Guidelines for Design and Construction of Health Care Facilities* published by the Facility Guidelines Institute with assistance from the US Department of Health and Human Services requires that an examination/treatment room, or area, shall meet the requirements of Section 2.1-3 Diagnostic and Treatment Locations including a minimum clear floor area of 120 square feet. These guidelines are recognized as the national standard for health care facilities in the United States, and serve as the model code for many states.
- The Veteran’s Administration 2005 Design Guide for Leased Outpatient Clinics also requires a minimum of 120 net square feet for an Examination Room. The DVA requirements for a gynecological (GYN) exam room adds the requirement of a dedicated accessible toilet, accessible directly from the exam room, for satellite / community-based outpatient clinics.

The required space in an examination room has grown over the years in response to additional equipment commonly used in such rooms.

- The US Department of Health, Education & Welfare, Health Resources Administration, published a design guide for Outpatient and Emergency Units in 1973. The minimum programmatic requirement for an exam room, in an outpatient department, was 80 net square feet.
- The American Academy of Family Practice published *Efficient Office Design for a Successful Practice* in 2007 and explores how much exam room space is truly necessary. They conclude that a 10 foot x 10 foot exam room, 100 square feet, is optimal and efficient, though not

necessarily the absolute minimum. They state that each exam room should have enough space to accommodate the physician, a nurse/assistant, the patient and at least one family member; they found that 8 foot x 8 foot is far too small to navigate in the room. They also noted that the 60 inch maneuvering area needs to be met per ADA Guidelines. This same 10 foot x 10 foot space is offered by Midmark Corporation as “the most efficient exam room design” to accommodate their exam tables, and is “intended to be fluid to meet the continually changing needs of physicians and the emergence of electronic medical records.”

- The 2010 *Guidelines for Design and Construction of Health Care Facilities* includes specific provisions for Diagnostic and Treatment Locations in Outpatient Facilities in Section 3.1 - 3. In these facilities (including Primary Care Outpatient Facilities) the minimum size for a Treatment Room is held to the clear floor area of 120 square feet, while a General Purpose Examination Room is allowed to have a minimum clear floor area of 80 square feet.
- The 2010 *Guidelines for Design and Construction of Health Care Facilities* also includes specific allowances for Examination and Treatment Locations in Small Primary Care Outpatient Facilities (defined as space and equipment to serve three or fewer examination rooms at any one time) in Section 3.3.-3. In these specific facilities, rooms are permitted to serve as both exam and treatment spaces with a minimum clear floor area of 80 square feet.

Roger Richter, representing the California Hospital Association (CHA), commented that the “*requirement of a minimum 80 square feet (7.4 m²) is a good minimum treatment room space, especially if the patient, a patient’s associate, a nurse and a physician need to be in the room at the same time. A number of hospitals actually use a higher minimum for this reason. The national Guidelines for Design of Health Care Facilities, in Section 3.1-3.2.2.2 recommends a minimum 80 square feet examination room in clinics such as those licensed under Title 22.*” Please see his comment to Section 1226.4.1.3.

California currently allows examinations to be performed in rooms as small as the 80 square feet of clear floor area per 2010 CBC Section 1224.4.4. This is the very minimum size allowed by any of the national standards. Facility design would normally respond to actual operational and functional requirements and likely result in larger exam rooms. The Express Terms provide only the minimum requirements.

The commenter offers an alternative to “further study” in compromise, suggesting that a minimum of 10% of the examination and treatment rooms, in all medical facilities, meet the 80 square foot requirement, as a response to the concern over accessibility, and allowing the remaining exam/treatment rooms to be held to a 70 square foot minimum requirement. Even if the suggested language was modified to relate to primary care clinics only and not to hospitals and skilled nursing facilities, the concept is in conflict with the requirements of CBC Chapter 11B or the requirements of ADA. Both of these sources currently require that all examination and treatment rooms be considered “common use” and consequently all of these rooms must be accessible to those with disabilities and not just a percentage. Professor Pendo, concludes in her paper *Disability, Equipment Barriers, and Women’s Health: Using the ADA to Provide Meaningful Access*: that “[ADA] Title II provides that qualified individuals with a disability cannot be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity. Similarly, Section 504 of the Rehabilitation Act prohibits discrimination against otherwise qualified individuals with a disability under any program or activity receiving federal financial assistance” and “... the ADAAG requires that all public and common use areas of a medical facility be accessible.”

Adoption of these building standards is in the public interest and is necessary for consistency with other parts of the building code to avoid confusion and misunderstanding. It is reasonable to provide for accessibility to exam rooms by the mobility impaired and to expect those rooms to function adequately in the administration of a physical exam. The Express Terms are based upon the minimum national standards available and do not introduce any new standard but only recognize the current requirements to provide accessibility to medical exam and treatment rooms in primary care clinics, in continued fairness to those having mobility impairments. The commenter suggests an amendment to the current Section 1224.4.4, that is proposed to be carried forward as 1224.4.4.1 without modifications. Since there are no proposed modifications, the suggested amendment is outside the rulemaking process. The Office held many outreach meetings with various stakeholders in the development of this provision, studied the background of this section, compared the requirements from various national sources, and believes that further study is not necessary. The Office will be making no change to this section.

Section 1226.8.3.2 Surgical Clinics Outpatient change area

Commenter: Carol Corr, Kaiser Permanente

The commenter suggested deleting the proposed language and recommended approval as amended based on Criteria #1. The KP universal way for patients to change is in prep and recovery cubicles. The patients are kept track of easier and reduced patient movement. In addition, the commenter understood the proposed code language added requirements beyond those in Section 1224.39 for inpatient surgery services.

OSHPD Response:

The commenter suggested the Kaiser procedure for patients to change in the preparation and recovery cubicles is more efficient for the KP universal way, than separate patient changing rooms. Because changing areas are common use areas CBC Chapter 11B requires they be 100% accessible. That means the preparation and recovery cubicles must have an accessible bench, clothing hooks, lockers to secure belongings, appropriate accessible dimensions on either side of the bed/gurney and the full length of the bed/gurney in the prep/recovery cubicle.

The proposed language for outpatient change areas is based on the 2010 Guidelines for Design and Construction of Health Care Facilities, used as a national "model code" source. (Refer to 3.9-3.8.1 Patient Change Areas) In addition, there is existing language in CBC Section 1226.17.9 Outpatient change area—A separate space shall be provided where outpatients change from street clothing and are prepared for surgery. This would include provisions for clothing storage, toilet room(s), sink space for clothing change and gowning area.

The patient changing area requirement acknowledges the provision for patient privacy per this code.

The Office will be making no change to this section.

- ***Public comments received during the 15-Day Public Comment Period from October 23, 2012 to November 6, 2012.***

Section 1226.4.13.2 Medication station

Commenter: Glenn Gall, OSHPD

The commenter requested to add language to Section 1226.4.13.2 and relocate originally proposed language from 1226.4.13.2 to 1226.4.13.2.1 to provide clarity that the medicine preparation room may be part of a nurse station or administrative center such that access to handwashing need not result in multiple handwashing fixtures.

OSHPD Response:

The proposed clarification is consistent with criteria point 6 and clarifies ambiguous or vague language. The Office will be making this change to the section.

DETERMINATION OF ALTERNATIVES CONSIDERED AND EFFECT ON PRIVATE PERSONS

OSHPD has determined that no alternative would be more effective in carrying out the purpose for which the regulation is proposed or would be as effective and less burdensome to affected private persons than the adopted regulation.

REJECTED PROPOSED ALTERNATIVE THAT WOULD LESSEN THE ADVERSE ECONOMIC IMPACT ON SMALL BUSINESSES:

OSHPD has determined that the proposed regulations will not have an adverse economic impact on small businesses.