AD HOC HEALTHCARE COMMITTEE

SUMMARY REPORT

WORK GROUPS: FIRE/FIRE SAFETY; GENERAL; EGRESS

12/7/2012

FIRE/FIRE SAFETY WORK GROUP REPORT

NEW CODE ISSUES

None at this time.

OUT-OF-SCOPE ISSUES/"PARKING LOT"

Issue #4C: Smoke control in OR's

Issue #4D: Moved here per AHC Meeting #2. An NFPA 99 issue.

Issue #10: This duplicates General WG Topic #8, and so is placed in the parking lot.

Issue #10A: System testing – A referenced standard issue. Moved here per AHC Meeting #2.

Issue # 11A: Medical Gas (O_2 outlets in pt. rooms)(per AHC #2)

ROUND 1 CROSS-OVER ISSUES

Issue #2: ELEVATOR RECALL PROCEDURES (Cross-over to MOE WG per AHC #2)

Issue #8: ROBOTICS IMPACT ON CORRIDOR WIDTH (Cross-over to MOE WG)

Issue #10: NEW AND EXISTING FACILITIES TO BE FULLY SPRINKLERED (General WG Topic 8)

Issue #13: CLINICAL LABS/HAZARDOUS EXHAUST (Cross-over to General WG)

ADDITONAL ISSUES TO BE BROUGHT TO AHC ATTENTION

None at this time.

FSWG PROGRESS ASSESSMENT

The Fire/Fire Safety Work Group has had a total of 26 teleconference calls --- every Thursday at 10:00 AM EDT, from May 12 through December 8, 2011.

WG member and interested party participation has been constructive. John Williams, the AHC chair and Jeff O'Neill, the AHC Vice-chair, have continued to participate in many of the teleconferences of this and the other WG's which has assisted in keeping the work group on track by providing some "big picture" insights and background information.

As seen in Parts I and II of the report, the Round 1 issues and all but one K-tag (K71) have come to a tentative conclusion with prepared code change proposals ready for review and approval by the AHC.

The FSWG Round 1 issues have also been reviewed by the ICC Code Technology Committee Care Study Group which is reviewing code requirements for care facilities other than hospitals. That review has resulted in eight of the FSWG Round 1 issues being approved for co-sponsorship by the CTC as indicated in the Part I Introduction.

GENERAL WORK GROUP REPORT

PART III – GENERAL INFORMATION

PART I: CURRENT CODE ISSUES:

TOPIC #1: Ambulatory Care. Complete. No proposal necessary

TOPIC #2: Defend in place. Proposal in part I of report.

TOPIC #3 Size of compartments. Two proposals in part I of report.

TOPIC #4 Use of facilities during renovations. Proposal in part I of report.

TOPIC #5 Hazardous materials locations. Addressed by FSWG

TOPIC#6 Incidental use areas. Addressed by FSWG

TOPIC #7 Seismic Requirements & Existing Buildings. Still needs to be addressed.

TOPIC #8 Smoke compartment alternative/tradeoff for fully suppressed buildings. Information was not presented to address concern. No proposals and no further work required at this time.

TOPIC # 9 Mixed Use and accessory occupancy provisions. Two proposals in Part I of report.

Topic # 10 K Tags/ Existing building issues non seismic. See Part II of the report for the current proposals on K-Tags. Note that Ambulatory care facilities have not been heavily addressed at this time with regard to K-Tags.

Topic # 11 Construction , Systems and Equipment requirements. Further work may be necessary. This issue deals with the possible need for redundant power etc.

Topic # 12 Existing standard references and terminology related to health care. Two proposals related to this topic in Part I of the report.

PART II: NEW CODE ISSUES:

1. Applicability of Section 422.

Definition of ambulatory care center does not have the 4 person cut off – therefore, literally all the provisions here are applicable to the defined term. The provisions were only intended if the space was required to be separated in accordance with 422.2.

422.1 General. Occupancies classified as *ambulatory care facilities* where the potential for four or more care recipients are to be *incapable of self preservation* at any time, whether rendered incapable by staff or staff accepted responsibility for a care recipient already incapable shall comply with the provisions of Sections ~~422.1~~ 422.2 through 422.7 and other applicable provisions of this code.

422.2 Separation. *Ambulatory care facilities* ~~where the potential for four or more care recipients are to be *incapable of self preservation* at any time, whether rendered incapable by staff or staff accepted responsibility for a care recipient already incapable~~ shall be separated from adjacent spaces, *corridors* or tenants with a *fire partition* installed in accordance with Section 708.

2. Stair access issues ambulatory care facilities.

Problem with no stairway requirement in the smoke compartment – can we use the direct access to stairways same as elevator lobby?

422.5 Independent egress. A *means of egress* shall be provided from each *smoke compartment* created by smoke barriers without having to return through the *smoke compartment* from which *means of egress* originated.

Some related discussion on 10/25/2011 conference call.

> *Possible lack of egress from smoke compartments based upon lack of clear direction in the code. Section 407.5.2 addresses independent egress but does not address directly*

the need for two means of egress from a smoke compartment. After discussion it was felt that the requirements in 1015 would likely get the two egress paths that would avoid this problem. See figure provided by John Williams

3. Continuity problem.

Need an exception for ambulatory health care that is a portion of a larger building and not on an outside wall. Note potential proposal below. See 422.3

709.4 Continuity. *Smoke barriers* shall form an effective membrane continuous from outside wall to outside wall and from the top of the foundation or floor/ceiling assembly below to the underside of the floor or roof sheathing, deck or slab above, including continuity through concealed spaces, such as those found above suspended ceilings, and interstitial structural and mechanical spaces. The supporting construction shall be protected to afford the required *fire-resistance rating* of the wall or floor supported in buildings of other than Type IIB, IIIB or VB construction.
Exceptions:
1. Smoke-barrier walls are not required in interstitial spaces where such spaces are designed and constructed with ceilings that provide resistance to the passage of fire and smoke equivalent to that provided by the smoke-barrier walls.
2. Smoke barriers used for elevator lobbies in accordance with Section 405.4.3, 3007.4.2 or 3008.11.2 are not required to extend from outside wall to outside wall.
3. Smoke barriers used for areas of refuge in accordance with Section 1007.6.2 are not required to extend from outside wall to outside wall.
4. Smoke barriers walls used to enclose smoke zones in ambulatory care facilities are not required to extend from outside wall to outside wall.

Notes from 4th Ad Hoc meeting: These ambulatory care facility questions need to be coordinated with defend in place and smoke compartments in general, but have the means of egress issues sent to MOE. Coordination important.

Note that this issue was discussed during the 10/25/2011 Conference call with the following discussion and conclusion.

John Williams provided some sketches for discussion. *Discussed issue of where smoke barriers can be located within a building. It was pointed out by John Williams that there is essentially an exception already for Ambulatory care facilities allowing smoke barrier to extend from outside wall to outside walls or to another smoke barrier. John Williams proposed that a code change to move with the other exceptions to 709 be made. This would place as exception 4 to 709. He felt that this is more consistent with existing code language and structure. Those on the call were acceptable to this approach.* ***John Williams was to draft up a proposal moving the exception language from 422.3 to 709 exception 4.***

Note there was some discussion as to why this did not apply to hospitals. It was noted that this is a logistic issue specific to ambulatory care facilities that are often in mixed occupancy buildings and placed into existing buildings. The need for this exception is very specific to ambulatory care facilities.

PART III: WG CROSS OVER ISSUES:

1. **Defend in place.** Defend in place concern communicated to the Fire safety work group. See notes under Topic #2 "defend in place" above.

2. **Egress Issues For Healthcare Occupancies.** Occupancy B & I-2. Proposal on Topic 9 addresses egress width.

3. **Smoke Compartment size.** Related to work by MOE WG with their investigations on Suite Sizes.

4. **Hazmat.** Addressed by FSWG.

5. **Incidental uses.** Addressed by FSWG

PART IV: FURTHER RESEARCH ISSUES:

None at this time.

Part V PARKING LOT Issues within Scope

TOPIC #7
SEISMIC REQUIREMENTS & EXISTING BUILDINGS.

This was placed in the parking lot initially due to the fact that existing building requirements were being dealt with later in the process. Generally seismic is dealt with in Chapter 34 and the IEBC throughout.

TOPIC #7 CONCLUSIONS.

Topic is on hold for future assignment & currently in the 'parking lot' given the majority of issues are related to existing facilities. See Part II New code issues

Part VI OUT-OF-SCOPE ISSUES:

Independent Emergency rooms/Emergency Healthcare facilities.
An issue was discussed during several conference calls regarding emergency rooms that are independent of the Group I-2 occupancy or separated from the Group I-2. It was noted that these facilities would either still be classified as I-2 or be classified as a Group B Ambulatory Care Facility; both classifications have been occurring across the country. Such facilities would not simply be considered Group B occupancies unless they were very small. The concern seemed to have more to do with licensing requirements; thus is outside the scope of this group.

Note that there is still some discussion in the mixed occupancy/ accessory occupancy requirements as to how these facilities, whether stand alone or in conjunction with a hospital, are classified (separated or non separated).

Statements were made by some workgroup members that this is possibly just one of many healthcare uses that may have individualized issues and/or requirements; however, given the rapidly increasing prevalence for the development of this type of facility, the General WG recommends that additional discussion, investigation and research is necessary to determine if possible code language would be advisable and emergency care facilities and requirements should be reviewed.

Notes from 4th Ad Hoc meeting:

- Should free-standing emergency departments be considered a general doctor's office (Group B), an Ambulatory Care Center (Group B with protection) or a hospital (Group I-2)?
- The 24 hours is based on patient stay, not the fact that the facility might be open 24 hours a day.
- If licensure or risk category would require different systems – redundant power, separate mechanical systems, etc. – that should be addressed.
- Description of an urgent care facility vs. an emergency care facility.
- Emergency care is an extension of a hospital.
- Urgent care is most likely an ambulatory care center.
- Let the licensure issues be addressed by the individual states.
- Add this issue to the Parking Lot.

During the 10/25/2011 conference call the following conclusions were drawn on this issue

One of the key concerns with this issue was that since patients are often incapable of self preservation before they arrive that they would not be counted as being rendered incapable and thus fall outside the Ambulatory care facility requirements. In addition, since the I-2 classification is intended to address a patient being cared for more than 24 hours this could fall into a simple B occupancy. After extensive discussion it was determined that a true emergency center also has the capability to render patients incapable due to the type of treatment they offer and will certainly fall within the ambulatory care facility scope.

It was also discussed whether they could call themselves "urgent care" and the group feeling was that urgent care is a very different type of facility from an operational and licensing standpoint and that was not a concern. In fact they are staffed by different kinds of doctors.

Therefore these standalone facilities will primarily be classified as Ambulatory Care Facilities due to the length of treatment and the type of treatment. ***No changes were recommended at this time as it was felt the current definition of Ambulatory care facility addressed and the requirements for such facilities were adequate.***

PART VII: ADDITIONAL ISSUES TO BE BROUGHT TO AHC ATTENTION

None at this time.

PART VIII: WG PROGRESS ASSESSMENT:

The General WG has had 26 conference calls between 1 ½ hours or 2 hours each from May 2011 to December 2011.

Of the Round 1 issues 8 proposals were produced dealing with 6 different topics. These proposals are briefly noted in Part I of this document and in Part I of the report overall.

There were 27 K-Tags assigned to this committee. Of these K-tags

- 11 of them have proposals associated with them.
- 12 do not need to be addressed as they are already covered or are not seen as a priority.
- 2 Are still under study
- 2 have been discussed but needs a change drafted (IFC) Incidental uses and separation of non conforming.

Note that several of the K-tag proposals were actually grouped to create more cohesive proposals for subjects like Smoke barriers in existing buildings. Additionally it should be noted that for many of these K-tags they need to be further analyzed for Ambulatory Care Facilities.

The GWG Round 1 issues have also been reviewed by the ICC Code Technology Committee Care Study Group which is reviewing code requirements for care facilities other than hospitals. That review has resulted in 3 of the GWG Round 1 issues being approved for co-sponsorship by the CTC as indicated in the Part I of the overall report Introduction.

MEANS OF EGRESS WORK GROUP COMMITTEE

PART III – GENERAL INFORMATION

NEW CODE ISSUES:

- Evacuation for all hazards not just fire
- Doors – swing, size, corridor overlap, break out, smoke seal, maneuvering clearances
- Renovations for suites or smoke compartment vs. new construction
- Means of egress issues for Ambulatory Care Facilities when a single tenant in a much larger Group B building
- Development of criteria in IFC Chapter 11 specific to hospitals.

Proposal for K-tags K17, K18, K37, K39, K42 (Code change in process):

Proposals from Adhoc Health for IFC Chapter 11
In Progress 11-13-2011

SECTION 1104
MEANS OF EGRESS FOR EXISTING BUILDINGS

1104.15 Width of ramps. In other than Group I-2, Existing *ramps* are permitted to have a minimum width of 30 inches (762 mm) but not less than the width required for the number of occupants served as determined by Section 1005.1. In Group I-2, existing corridors, aisles and ramps have a minimum width of 48 inches.

Exceptions: In Group I-2, ramps serving smoke compartment not housing patient sleeping rooms, treatment rooms, and or used for means of egress from a patient area shall have a minimum width of 44 inches. Such ramps serving an occupant load of less than 50 shall have a minimum width of 36 inches.

1104.17 Corridors. In other than Group I-2, *Corridors* serving an *occupant load* greater than 30 and the openings therein shall provide an effective barrier to resist the movement of smoke. Transoms, louvers, doors and other openings shall be kept closed or self closing.

Exceptions:

1. Corridors in occupancies other than in Groups H ~~and I-2,~~ which are equipped throughout with an approved automatic sprinkler system.
2. ~~Patient room doors in Corridors in occupancies in Group I-2 shall comply with the requirements of 1104.17.2 where smoke barriers are provided in accordance with the International Building Code.~~
3. Corridors in occupancies in Group E where each room utilized for instruction or assembly has at least one-half of the required means of egress doors opening directly to the exterior of the building at ground level.
4. Corridors that are in accordance with the International Building Code.

1104.17.2 Corridors in Group I-2. In Group I-2, corridors and the openings therein shall provide an effective barrier to resist the movement of smoke.

Exceptions:

~~1. Corridor walls and doors enclosing spaces required to be separated by fire resistance rated construction in other sections of this code shall meet those requirement and shall be constructed in accordance with Section 716 of the *International Building Code* for the required fire resistance.~~
2. Opening protectives are not required for spaces open to the corridor and constructed in accordance with section 407.2~~.1~~ of the *International Building Code* where such spaces are constructed as required for corridors.
~~3. Spaces for doctors' and nurses' charting, communications and related clerical areas shall be permitted to be open to the corridor, where such spaces are constructed as required for corridors.~~
~~4. Gift shops and associated storage that are less than 500 square feet (455 m2) in area shall be permitted to be open to the *corridor* where such spaces are constructed as required for *corridors.*~~

5. Corridors that are in accordance with the International Building Code.

1104.17.2.1 Corridor Walls. Corridor walls shall be constructed to resist the passage of smoke and shall be continuous from the floor to the deck above or to a ceiling constructed to resist the passage of smoke that will withstand an uplifting force of one pound per square foot.

1104.17.2.2 Openings in corridor walls. Corridor openings shall be protected with doors and frames constructed of materials to resist the passage of smoke as indicated below:

1. Doors shall be positive latching.
2. Dutch door shall be equipped with positive latching devices on both the top and bottom leaves. The top and bottom leaves shall be protected with devices such as astragals to prevent the passage of smoke in the space between the door leaves.
3. Roller latches shall not be used.
4. Doors shall not be held open unless by an approved automatic closing hold open device in accordance with section 716 of the *International Building Code*.
5. Frames for side hinged swinging doors shall have stops on the sides and top to limit transfer of smoke.
6. Doors shall not be undercut greater than 1 inch.
7. Fixed glass window assemblies shall be permitted on unlimited size when installed to restrict the passage of smoke.
8. Louvers, transfer grills or similar opening shall not be permitted.

    Exceptions:

    1. Doors to auxiliary spaces such as toilet rooms, bathrooms, sink closets that do not contain storage or flammable or combustible materials or are not required to be separated by other provisions of this code shall be permitted to have ventilating louvers or to be undercut.
    2. Corridor walls in smoke compartments not containing patient sleeping rooms may contain unprotected pass-through windows or similar openings not greater than 80 in^2 in each room not required to be separated by other provisions of this code.

1104.17.2.3 Means of egress sizing in Group I-2. Existing corridors, aisles and ramps shall not be less than 48 inches in clear and unobstructed width.

Exceptions:

1. Corridors serving smoke compartment not housing patient sleeping rooms, treatment rooms, and or used for means of egress from a patient area shall be not less than 44 in clear width. Such corridors serving an occupant load of less than 50 shall be not less than 36 in clear width.
2. Existing corridors shall not be reduced to less than the width required by the code under which they were constructed.
3. Clean, soiled linen and food carts may be within the required clear width when in use, attended by the staff using the carts, and within two doors of the rooms being served.
4. Corridors at least 72 inches in clear width may have projections of not more than 6 inches above the handrail for hand sanitizers, nurses' and doctors' charting and similar equipment.
5. Corridors at least 8 feet in clear width may have projections into the required clear width as permitted by 1005.7 of the *International Building Code.*

1104.17.2.4 Dead end corridors. Dead end corridors exceeding 30 feet shall be prohibited.

Exceptions:

1. Existing dead end corridors serving smoke compartment housing patient sleeping rooms, treatment rooms, and incidental uses may exceed a dead end of 30 feet where not practical to correct.
2. Existing dead end corridors not serving smoke compartment housing patient sleeping rooms, treatment rooms, and incidental uses shall comply with 1104.17.3.

1104.17.2 Dead ends. Where more than one *exit* or *exit access* doorway is required, the *exit access* shall be arranged such that dead ends do not exceed the limits specified in Table 1104.17.2.

Exceptions:

1. A dead-end passageway or *corridor* shall not be limited in length where the length of the dead end passageway or *corridor* is less than 2.5 times the least width of the dead-end passageway or *corridor*.
2. Dead end corridors in Use Group I-2 shall comply with 1104.17.4.

TABLE 1104.17.2
COMMON PATH, DEAD-END AND TRAVEL DISTANCE LIMITS (by occupancy)

OCCUPANCY	COMMON PATH LIMIT		DEAD-END LIMIT		TRAVEL DISTANCE LIMIT	
	Unsprinkled (feet)	Sprinkled (feet)	Unsprinkled (feet)	Sprinkled (feet)	Unsprinkled (feet)	Sprinkled (feet
Group I-1	75	75	20	50	200	250
Group I-2 (Health care)	NR[e]	NR[e]	~~NR~~ Note f	~~NR~~ Note f	150	200[c]
Group I-3 (Detentional—Use Conditions II, III, IV, V)	100	100	NR	NR	150[c]	200[c]
Group I-4 (Day Care Centers)	NR	NR	20	20	200	250

(Portions of table not shown remain unchanged)

NR = No requirements.
For SI: 1 foot = 304.8 mm, 1 square foot = 0.0929 m2.
a. 20 feet for common path serving 50 or more persons; 75 feet for common path serving less than 50 persons.
b. See Section 1028.9.5 for dead-end aisles in Group A occupancies.
c. This dimension is for the total travel distance, assuming incremental portions have fully utilized their allowable maximums. For travel distance within the room, and from the room exit access door to the exit, see the appropriate occupancy chapter.
d. See the *International Building Code* for special requirements on spacing of doors in aircraft hangars.
e. Any patient sleeping room, or any suite that includes patient sleeping rooms, of more than 1,000 square feet shall have at least two exit access doors placed a distance apart equal to not less than one-third of the length of the maximum overall diagonal dimension of the patient sleeping room or suite to be served, measured in a straight line between exit access doors.
f. Existing dead end corridors in Group I-2 shall comply with Section 1117.2.4. .
g. ~~f.~~ Where a tenant space in Group B, S and U occupancies has an occupant load of not more than 30, the length of a common path of egress travel shall not be more than 100 feet.

1104.18 Group I-2 care suites. *Care suites* in Group I-2 shall comply with Section 1104.18.1 through 1104.18.2 and either Section 1104.18.3 or 1104.18.4.

1104.18.1 Exit access through care suites. *Exit access* from all other portions of a building not classified as a *care suite* shall not pass through a *care suite*. In a *care suite* required to have more than one *exit*, one *exit access* is permitted to pass through an adjacent *care suite* provided all of the other requirements of Sections 407.4 and 1014.2 are satisfied.

1104.18.2 Separation. *Care suites* shall be separated from other portions of the building by a smoke partition complying with Section 710.

1104.18.3 Number of doors. Movement of beds from the patient sleeping rooms out of the care suite shall not require passage through more than 3 doors.

1104.18.4 Care suites containing sleeping room areas. Sleeping rooms shall be permitted to be grouped into *care suites* with one intervening room if one of the following conditions is met:

1. The intervening room within the *care suite* is not used as an *exit access* for more than eight care recipient beds.

2. The arrangement of the *care suite* allows for direct and constant visual supervision into the sleeping rooms by care providers.

3. An automatic smoke detection is provided in the sleeping room in accordance with Section 907.

1104.18.4.1 Area. *Care suites* containing sleeping rooms shall be not greater than 7,500 square feet (696 m^2) in area.

Exception: *Care suites* containing sleeping rooms shall be permitted to be not greater than 10,000 sq feet (929 m^2) in area where the building is protected throughout by an approved automatic sprinkler system and the suite complies with one of the following:

1. All sleeping rooms are provided with constant visual supervision into the sleeping rooms by care providers
2. An automatic smoke detection system is provided throughout the *care suite* in accordance with Section 907.

1104.18.4.2 Exit access. Any sleeping room, or any *care suite* that contains sleeping rooms, of more than 1,000 square feet (93 m^2) shall

have no fewer than two *exit access* doors from the care suite located in accordance with Section 1015.2.

1104.18.4.3 Travel distance. The travel distance between any point in a *care site* containing sleeping rooms and an *exit access* door from that care sure shall not be greater than 100 feet (30 480 mm).

Exception: The travel distance shall be permitted to be increased to 125 feet (38 100 mm) where the building is protected throughout by an approved automatic sprinkler system and the suite complies with one of the following:

1. All sleeping rooms are provided with constant visual supervision into the sleeping rooms by care providers
2. An automatic smoke detection system is provided throughout the *care suite* in accordance with Section 907.

1104.18.5 Care suites not containing sleeping rooms. Areas not containing sleeping rooms, but only treatment areas and the associated rooms, spaces or circulation space shall be permitted to be grouped into *care suites* and shall conform to the limitations in Section 1104.18.5.1 and 1104.18.5.2.

1104.18.5.1 Area. *Care suites* of rooms, other than sleeping rooms, shall have an area not greater than 10,000 square feet (929 m^2).

1104.18.5.2 Exit access. *Care suites*, other than sleeping rooms, with an area of more than 2,500 square feet (232 m^2) shall have no fewer than two *exit access* doors from the *care suite* located in accordance with Section 1015.2.

1104.22 Minimum aisle width. The minimum clear width of *aisles* shall be:

1. Forty-two inches (1067 mm) for *aisle* stairs having seating on each side.
   Exception: Thirty-six inches (914 mm) where the *aisle* serves less than 50 seats.
2. Thirty-six inches (914 mm) for stepped *aisles* having seating on only one side.
   Exception: Thirty inches (760 mm) for catchment areas serving not more than 60 seats.
3. Twenty inches (508 mm) between a stepped *aisle* handrail or guard and seating when the *aisle* is subdivided by the *handrail*.
4. Forty-two inches (1067 mm) for level or ramped *aisles* having seating on both sides.
   Exception: Thirty-six inches (914 mm) where the *aisle* serves less than 50 seats.
5. Thirty-six inches (914 mm) for level or ramped *aisles* having seating on only one side.
   Exception: Thirty inches (760 mm) for catchment areas serving not more than 60 seats.

6. Twenty-three inches (584 mm) between a stepped *stair handrail* and seating where an *aisle* does not serve more than five rows on one side.

7. Aisles in Group I-2 shall comply with 1104.17.2.3.

WG CROSS OVER ISSUES:

- The Fire Safety work group referred a proposal for delayed egress locks to the MOE work group. The MOE work group is looking at locking for security/wandering issues. Coordination/communication needs to be maintained in this area.
- CMS Survey tool for existing buildings – Fire Code committee

FURTHER RESEARCH ISSUES:

Information on how elevators are used during different emergencies.

From #1 Elevator comments above:

AHC could check with NIST or ASME to see if there has been any occupant evacuation models with hospitals either during a general evacuation (i.e., flood, hurricane, tornado) or during a fire event. Is there any history on a hospital needing to do a building evacuation for a fire event? ASHE will provide general building evacuation studies.

OUT-OF-SCOPE ISSUES:

None at this time

ADDITONAL ISSUES TO BE BROUGHT TO AHC ATTENTION

None at this time

WG PROGRESS ASSESSMENT:

The MOE work group has teleconferences every Friday, from approximately 10:00 to 11:30 EST. At the writing of this report we have had 26 teleconferences.

Of the 5 areas of study, the committee has proposals for all 5. See the report for Part I. There are 14 code change proposals.

There were 26 K-Tags assigned to this committee. Of these K-tags

- 9 of them have proposals associated with them.

- 11 do not need to be addressed as they are already covered or are not seen as a priority.
- 5 Are still under study

The MOE WG Round 1 issues have also been reviewed by the ICC Code Technology Committee Care Study Group which is reviewing code requirements for care facilities other than hospitals. That review has resulted in 7 of the MOE WG Round 1 issues being approved for co-sponsorship by the CTC as indicated in the Part I of the overall report Introduction.