Preface

The 2006 edition is the latest in the 59-year history of this Guidelines document to aid in the design and construction of health care facilities.

The original *General Standards* appeared in the *Federal Register* on February 14, 1947, as part of the implementing regulations for the Hill-Burton program. The standards were revised from time to time as needed. In 1974 the document was retitled *Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities* to emphasize that the requirements were generally minimum, rather than ideal standards. The 1974 edition was the first to request public input and comment. Requirements relating to the preparation of plans, specifications, and estimates or to site survey and soil investigation, which had been a part of all previous editions, were removed. These requirements were published in a document entitled *Technical Manual on Facility Design and Construction* published by the Department of Health, Education, and Welfare's (DHEW) Office of Facilities Engineering.

In 1984 the Department of Health and Human Services (DHHS) removed from regulation the requirements relating to minimum standards of construction, renovation, and equipment of hospitals and medical facilities, as cited in the *Minimum Requirements*, DHEW Publication No. (HRA) 81-14500. Since the federal grant and loan programs had expired, there was no need for the federal government to retain the guidelines in regulation format. To reflect its nonregulatory status, the title was changed to *Guidelines for Construction and Equipment of Hospital and Medical Facilities*. However, the document was, and still is, used by many state authorities having jurisdiction for licensure or registration. Further, the Guidelines are used by DHHS staff to assess Department of Housing and Urban Development applications for hospital mortgage insurance and for Indian Health Service construction projects. Therefore, regulatory language has been retained. The 1983–84 edition of the Guidelines was the last one revised and published by the federal government; at the same time, DHHS published and distributed an addendum to the Guidelines entitled *Energy Considerations for Hospital Construction and Equipment*.

At the conclusion of the revision cycle that resulted in the 1983–84 edition, DHHS asked the American Institute of Architects Committee on Architecture for Health (AIA/CAH) to form an advisory group to work with, and be funded by, the Public Health Service for the next revision. When the revisions to the document were complete, the federal government declined to publish it. The AIA/CAH asked several nonprofit agencies and professional associations to publish and distribute the Guidelines. An agreement was finally reached with the American Institute of Architects (AIA) to publish the 1987 edition. At this point, revision of the Guidelines would have ceased, or even its existence, if three people had not taken it upon themselves to approach the Public Health Service and the Health Care Financing Administration and request a federal grant to fund a revision cycle. These same three people, working with AIA/CAH, put together the first Steering Committee, which in turn set up the first Health Guidelines Revision Committee (HGRC) not under the aegis of the federal government.

The members of this multidisciplinary group came from the federal and state governments and the private sector and offered expertise in design, operation, and construction of health care facilities. The 1992–93 edition of the Guidelines was published and distributed by the AIA. The Steering Committee from the 1992–93 cycle requested and received federal funding from DHHS for another cycle. Substantial funding was also provided by the American Hospital Association and the AIA/CAH. The consensus process was enhanced and the input base broadened by asking the public to propose changes to the Guidelines and then to comment on the proposed changes. Approximately 2,000 proposals and comments were received and processed. Three HGRC meetings—one on the East Coast, one on the West Coast, and one in the middle of the country—were held to discuss the merits of all proposals and comments. More than 65 experts attended these sessions and reached a consensus on the content of the 1996–97 edition of the Guidelines. A letter ballot was sent to all eligible members of the HGRC and the document was approved by a unanimous vote. To better reflect its content, the title of the document was changed to *Guidelines for Design and Construction of Hospital and Health Care Facilities*.

It was during this revision cycle that the AIA Committee on Architecture for Health became the AIA Academy of Architecture for Health (AIA/AAH).

In an effort to create a more formal procedure and process and to keep the document current, the Facility Guidelines Institute (FGI) was founded as an independent, not-for-profit 501(c)(3) corporation in 1998. The main objectives of FGI are (1) to see that the Guidelines are reviewed and revised on a regular cycle with a consensus process carried out by a multidisciplinary group of experts from the federal, state, and private sectors, (2) to stimulate research in support of evidence-based guidelines, and (3) to reinvest all of the net revenue derived from FGI's share of the sale of Guidelines documents in research and development for improved future editions of the Guidelines. FGI, in its role as a promulgator of health care facility guidelines and standards, contracts with the American Institute of Architects for support of the consensus revision process and publication of the document.

FGI is primarily interested in consensus methodology and in overseeing the Guidelines revision process. Specifically, FGI wants to make sure the Health Guidelines Revision Committee

- is properly funded,
- has a balance of stakeholder representation from individuals with expertise or jurisdiction,
- uses the consensus process,
- requests public input in the form of proposals for change and comments on proposed changes,
- reviews and revises the Guidelines on a timely basis to maintain a balance between minimum standards and the state of the art in health care design and construction, and
- operates under a formal set of bylaws governing its purpose, scope, membership, and goals that includes standing rules governing voting procedures, recognized duties and responsibilities for committee members, and established rules regarding appointments, terms, and officers.

FGI monitors requests for interpretations from the public. Goals are to make sure that requests are answered in a timely manner, interpretations are rendered by the individuals best equipped to reflect the intent of the committee when the document was written, and interpretations are made available to the public.

The 2001 edition of the Guidelines resulted from the first revision cycle to be completed under the aegis and direction of FGI. It received major funding from DHHS/Health Care Financing Administration and the AIA/AAH. The American Society for Healthcare Engineering (ASHE), the National Institutes of Health (NIH), and the AIA provided staff and technical support. The HGRC met in Washington, D.C., and reviewed the 1996–97 edition of the Guidelines line by line to ascertain issues that needed to be addressed, including infection control, safety, and environment of care. The membership for this revision cycle included an increased number of state authorities having jurisdiction (AHJs), consistent with the increasing number of states utilizing all or portions of the Guidelines as state regulation by adoption. The work of the HGRC was greatly enhanced by the attendance and participation of these AHJs.

At the beginning of the 2001 revision cycle, an announcement requesting proposals for change to the document was made in health care industry publications. The HGRC received and gave serious consideration to 539 proposals to modify the document. After the HGRC meeting in Irvine, California, a document containing proposed changes was made available for public comment. The HGRC received and gave careful consideration to 1,030 comments on the proposed changes. For the first time, the Internet was used extensively to distribute the draft of the document and to receive proposals and comments.

The 2001 Guidelines were the result of many hours spent at three meetings, each attended by 82 to 86 members of the 97-member HGRC. Committee members spent countless hours in subcommittee and focused task groups reviewing the proposals for change and comments on them. Text for the 2001 edition of the Guidelines formally adopted at the final HGRC meeting in Denver was sent to the HGRC members for letter ballot. The result of the ballot process was an overwhelming endorsement of the

document. The adopted Guidelines were approved by FGI and turned over to the AIA for publication and distribution. A major change in format was adopted for this edition, placing appendix material at the foot of the relevant pages in the main text. A glossary of terms and a form to request an interpretation were added to the book.

The 2006 edition of the Guidelines also received major funding from DHHS/Centers for Medicaid and Medicare Services, ASHE, and NIH, and the AIA again provided staff and technical support. This edition was also the result of many hours of formal and informal meetings on the part of more than 107 HGRC members. There were never fewer than 85 members present at the three "all-hands" meetings in Washington, D.C.; Austin, Texas; and Irvine, California; and 67 individuals faithfully attended every session. Committee members spent untold hours at "all-hands" meetings and subcommittee and focused task group meetings, as well as time outside the meetings, writing proposals and reviewing proposed changes and comments. They reviewed 797 proposals for change and 1,156 comments on proposed changes. The HGRC reached a consensus at its final meeting and unanimously endorsed the revised guidelines to be sent out for letter ballot. The result of the letter ballot was unanimous approval of the 2006 document. The HGRC also elected a new Steering Committee for the 2010 revision cycle.

The 2006 HGRC took on the challenge of two goals stated in the preface of the 2001 edition: to prepare more committee-generated changes to reflect the collective knowledge and experience of the members and to improve the format, readability, and indexing or searchability of the document to make it a more useful and user-friendly tool. The HGRC developed a number of work groups and added time to the revision cycle to draft proposals for new language. The committee also approved a complete reorganization to make the Guidelines more accessible to users. This time-intensive effort has resulted in a book presented in four parts: one with information applicable to all health care facility types, one on hospitals, one on ambulatory care facilities, and one for other health care facilities. (Details about the reorganization appear in the Major Additions and Revisions section that follows this preface.)

When possible, the Guidelines standards are performance oriented for desired results. Prescriptive measurements, when given, have been carefully considered relative to generally recognized standards. For example, experience has shown that it would be extremely difficult to design a patient bedroom smaller than the size suggested and still have space for the normally expected functions and procedures.

Authorities adopting the Guidelines should encourage design innovation and grant exceptions where the intent of the standard is met. These standards assume that appropriate architectural and engineering practice and compliance with applicable codes will be observed as part of normal professional service.

The Guidelines change to keep pace with evolving health care needs and in response to requests for up-to-date guidance from health care providers, designers, and regulators. It is recognized that many health care services may be provided in facilities not subject to licensure or regulation, and it is intended that these Guidelines be suitable for use by all health care providers. It is further intended that when used as regulation, some latitude be granted in complying with these Guidelines so long as the health and safety of the occupants of the facility are not compromised.

In some facilities, areas, or sections, it may be desirable to exceed the Guidelines standards for optimum function. For example, door widths for inpatient hospital rooms are noted as 3 feet 8 inches (1.11 meters), which satisfies applicable codes, to permit the passage of patient beds. However, widths of 3 feet 10 inches (1.22 meters) may be desirable to reduce damage to doors and frames when beds and large equipment are frequently moved. The decision to exceed the standards should be included in the functional program of the health care facility.

The Guidelines and the methodology for revising them have been, and still are, evolving. When first published, the document comprised a set of regulations developed by a single department of the federal government as a condition for receiving a federal hospital construction grant under the Hill-Burton Act. Even in those early days, the document was highly respected and influential throughout the world. From the time it was first issued and enforced, U.S. hospitals

have become the ideal and the goal to be achieved by those building hospitals in all nations.

Gradually, state hospital authorities and other federal agencies were added to the HGRC, then private, nongovernmental health care professional societies, practitioners, and designers. Educational programs and seminars were introduced in the 1980s to inform the public about the subjects addressed in the Guidelines and the reasons for inclusion of certain requirements. Very slowly, public input was requested by the committee in the form of comment on proposed changes. This has now exploded into the current avalanche of proposals and comments. In each succeeding cycle, the committee has been enlarged to increase the base of expertise and to allow more public representation. Further, the consensus procedure was adopted for all decision-making.

As the process became more complex, as the committee grew larger, as more and more public proactive and reactive input was requested and received, as the practice of health care delivery and the buildings that house them began to change at an ever faster rate, a more formal and expeditious process became mandatory. Adding to the complexity of the process is the expansion in the scope of the document from covering only acute care general hospitals to including nursing homes, rehabilitation facilities, ambulatory care facilities, psychiatric hospitals, mobile health care units, hospice care, assisted living, and so on.

It is the desire of the Health Guidelines Revision Committee to continue working with the American Institute of Architects and the Facility Guidelines Institute to make certain the Guidelines and the revision process continue. The HGRC does, however, wish to maintain its independence as an objective, multidisciplinary committee, operating without pressure from any organization and arriving at conclusions candidly, fairly, and knowledgeably through an open consensus process.

It is also the desire of the HGRC to see that the process continues to improve with each passing cycle. Some goals for the future follow:

- Seek more public input from a wider base, not only from professionals but from patients and other consumers.
- Encourage and sponsor research projects to support the evidence-based decision-making process.
- Allow more time to study and evaluate proposals for changes and to comment on recommended changes.
- Improve the committee's ability to communicate and receive information electronically, making full use of the Internet and other formats and programs as they become available. This would include requests for interpretation, tentative interim amendments, etc.
- Work constantly to improve the process and the content of the Guidelines to keep it a dynamic document that truly reflects the state of the art.
- Continue to have the courage and wisdom to adopt requirements that are forward looking and address the needs of the future, looking backward only to discover what not to do.
- Continue to strive for a document that is credible, reasonable, and knowledge-based and that will maintain the tradition of the American hospital as the role model for the rest of the world.

This publication supersedes the *Guidelines for Design and Construction of Hospital and Health Care Facilities*, 2001 edition.

Inquiries or questions about interpretations of the Guidelines may be addressed to:
The Facility Guidelines Institute
1919 McKinney Avenue
Dallas, TX 75201
www.fgi-guidelines.org

Questions about the Guidelines revision process may be addressed to:
The American Institute of Architects
Knowledge Resources Department
1735 New York Avenue, N.W.
Washington, DC 20006
202-626-7367 or 800-242-3837
healthcareguidelines@aia.org

To order copies of the Guidelines, call 202-626-7541 or 1-800-AIA-3837 (menu option 4) or send an e-mail to bookstore@aia.org.