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# Season 2 Episode 1 What’s New in the 2026 *FGI Facility Code* Draft (Recorded at the ASHE Health Care Facilities Innovation Conference on July 21, 2024) —Transcript—

[Intro music: “Skip to My Lou” by Neal Caine Trio]

# Sponsorship

[00:00:01] **Bridget McDougall:** This episode of *Between the Lines with FGI* is brought to you by the American Society for Health Care Engineering: Optimizing health care facilities.

[Music fades out.]

# **Intro**

[00:00:14] **Leah Hummel:** We live and breathe codes and standards and compliance and regulation because it's so critical to the services that we provide.

[Intro music: “Skip to My Lou” by Neal Caine Trio]

[00:00:26] **Bridget:** Welcome to season 2 of *Between the Lines with FGI*. This is Bridget McDougall, associate editor with FGI and your cohost along with John Williams, FGI’s senior vice president of content and outreach and chair of the 2026 Health Guidelines Revision Committee. In this podcast series, we take you between the lines of the codes to explore the stories and answer questions that reside there. For this season opener, we pick up on a conversation that John Williams and I had with Leah Hummel while at ASHE’s Health Care Facilities Innovation Conference, July 21st through 24th in Anaheim, California.

With the 2026 draft documents available for public comment now until September 30[2024], this is an episode you won't want to miss. John and I start off by sharing about some significant changes with the document itself, and then Leah joins us for an overview of new and revised requirements in the 2026 draft.

We're going to mention a lot of different parts of the draft in all three documents, so, look for the show notes; we will make a list there of every section that we reference so you know where to go. Sit back, enjoy, and let's get ready to read between the lines.

[Music fades out.]

[00:02:02] **John Williams:** There are some changes that you'll be sure to notice in the draft, and at first, they may seem like they're maybe cosmetic or they may even seem significant, but to be sure the content and the sensibility and the overall approach of how we're developing the content has not changed.

[00:02:18] **Bridget:** What was the *Guidelines for Design and Construction of Hospitals* you will see is named the *FGI Facility Code for Hospitals*; the outpatient document is the *FGI Facility Code for Outpatient Settings*; and the residential document is the *FGI Facility Code for Residential Care and Support Settings*. So, same documents, different titles.

[00:02:41] **John:** Not only is this a name change, it's a fundamental change in the approach of how we deliver some of the content. If you recall, previous versions of the *Guidelines* have both mandatory language requirements and non-mandatory guidance. The mandatory language is above the line or the code itself. The non-mandatory language is appendix, and this often comes in the form of advice or examples or alternative methods or maybe even the intent of why a code was developed in the first place. Going forward, we're going to make a clean split: mandatory requirements are going to be in the code; non-mandatory advice is going to be in a series of handbooks that are produced and delivered concurrently with the code.

[00:03:33] **Bridget:** And when you log on to fgiguidelines.net to review the documents and perhaps submit a comment on the draft, you're not going to see any of that previous appendix language there in the system.

[00:03:47] **John:** That's going to show up in a different document, released about the same time, but a different document.

[00:03:53] **Bridget:** We're really encouraging everybody to go online, take a look at our draft documents in full. You can go to fgiguidelines.net, and on that site, you can also submit comments, if you'd like, on any part of the draft document that is made available. But for now, let's go back to our conversation with Leah Hummel and hear about some of the biggest changes in the 2026 draft document. Enjoy.

[Sound of soft descending chimes.]

[00:04:25] **Bridget:** Let's talk about that 2026 document. I'm excited. Of the changes that are happening in the draft document, is there one that comes to mind to you personally that you're excited about?

[00:04:35] **Leah:** Well, you know, one proposal that I am very interested in is the one that deals with rural emergency hospitals. I am a small-town girl; I grew up in a tiny little farming community without a stoplight. It was so small. And you know, I've seen firsthand throughout my life how these rural hospitals are really struggling to keep their doors open, and you look at the number of hospitals that are at risk of closure in rural America right now, and it's very, very concerning. And so, I think what Center for Medicare & Medicaid Services has done with this new provider designation, the Rural Emergency Hospital, or REH, is really going to be a lifeline to some of those, rural communities. So, instead of having acute care beds in the hospital, they'll maybe be able to transition those beds to long-term care and still keep those emergency services that are needed to at least be able to triage those patients and get them to a larger facility in a more densely populated area.

So, I think it's great that FGI is addressing that topic. I think there's more work to be done as we learn more about it. You know, hospitals are just now beginning to do those conversions, but by referencing the existing critical access hospital for those types of services, I think we've given them a good framework to be able to start those types of projects.

[00:05:55] **John:** Yeah, and we got really curious over the past year with people in that position on the rural side of things and designers who understand the challenges of switching from one designation type to the other, and I guess the question that we had was, “Do we create a totally new chapter for this thing or is there a way to make that switch easier?” Because if I understand it, CMS is envisioning this almost as a switch that you can flip to go to a rural emergency hospital, and then they give you the opportunity to go back to a critical access hospital, and as you and I know, switching an occupancy or maybe a license designation, that has an overlay of, you know, a lot of different things. The questions come up, “Well, are you changing occupancy types? Are you looking at it as a newly constructed building because you're switching license type?” So the approach that you'll see in the draft is the idea that it's really just part of that critical access hospital chapter, and hopefully, what that does is it makes it easier for AHJs to imagine that this is kind of an on-and-off switch, or a REH versus CAH switch, and make that transition easier if people find value in that. So, that's the approach we've taken, and [I’m] really curious to see what people think about that.

[Three bass note, jazzy musical interlude.]

[00:07:19] **Bridget:** How about you, John?

[00:07:20] **John:** Well, the one that I think of that has been just this ongoing conversation for decades and decades is this concept of “How do we design a[n] operating room or a procedure room and really know what kinds of procedures can be done in each of those types of rooms?” And over the past 20 or 30 years, I think we've done it a lot of different ways. We've said, “All right, well, if the architect calls it an operating room, here's how many square feet it needs to be, and if they call it a procedure room, here's how many square feet it needs to be.” And then back in the early 2000s, we took an approach where we looked at the American Society of Anesthesiologists classification rating, and I think there were three classes: Class A, B, or C, or Class I, II, or III, I can't remember, but anyway, it was based on the level of anesthesia that you do in these rooms. And the level of anesthesia, the maximum level of anesthesia, would drive how big your room is, and it's a mechanism that you could use, it’s an approach, but we found that that ended up in a lot of weird situations where the answer wasn't really calibrated correctly. Then we tried a couple of different words like “invasive.”

[00:08:31] **Bridget:** Oh, you said the word.

[Ominous sound of thunderclap.]

[00:08:37] **John:** We tried “percutaneous” for a little while and used some of those definitions as a watershed point, but we struggled with getting really, the industry, even clinicians, to agree on what some of those words meant. So, now, in 2026, you'll see a different approach which sort of extracts itself from looking at “invasive procedure” and proposes using something that we're familiar with in other parts of the document, and that's a risk assessment—to look at not just one thing, not just one question, but multiple questions to figure out how big should a [clinical] room be. We don't want to get in the way of a clinical decision that a clinician might use to say, “All right, I'm going to do this procedure, and I think it's safe in that room,” but really try to address that planning decision that happens before a clinician even gets involved on a particular case. It's where the owners, the designers, the clinicians, the strategic look at building a building and saying, “All right, how many operating rooms do I need? How many procedure rooms do I need?” and then informing the clinical staff about the risks in each of those rooms and trying to have a much more robust conversation about it. Rather than [using] the name on the plans or what class of anesthesia [to determine what procedures can be done in the room], ask a bunch of questions, and get really curious about it, and help people land in the right number of rooms in the right size of rooms. To me that's gonna be an interesting addition.

[00:10:08] **Leah:** Yeah, I was never comfortable with clinicians asking architects if they could do X procedure in Y room. That never made sense to me, and so now that is being flipped, and it's up to the clinicians to decide what type of room they're going to do their procedures in.

[00:10:25] **John:** And these safety risk assessments that we do, many of them are multidisciplinary, and that's the opportunity to create this translation sort of bridge between different types of professionals. A clinician will not always know what the air quality is when they go into a room because they haven't seen the plans, [they] haven't been involved in the engineering that makes those kinds of decisions, so coming up with this common set of language around what it means and how safe a room is, I think is something that we haven't made available before.

[00:10:59] **Leah:** Yeah, you know, we talk about multidisciplinary teams all the time, and it brings to mind the ICRA, the infection control risk assessment, and we're always talking about how the group that develops the ICRA really needs to represent all kinds of different backgrounds because everybody comes to that discussion with different things in their mind that are affecting the work that they do, and so only by coming together and discussing all of these can you relate to all of those needs.

[Three bass note, jazzy musical interlude.]

[00:11:30] **John:** So, how about you, Bridget? What’s your big point of excitement?

[00:11:33] **Bridget:** Actually, it was what you said because it's one of the queries we get the most with FGI staff is, “Can I do this procedure in this particular room?” But if I had to pick another one, it would be behavioral health crisis centers. That was introduced last cycle in 2022, and it was kind of buried in the document. You had to go deep, deep within the hallways of the document and several floors [down] to find the language. So, it was exciting that the language was there, but it wasn't very visible, and it wasn't quite right. And what I'm excited about is after talking to Dr. Scott Zeller on episode 5 about crisis centers, what's in the draft now, in this new chapter that specifically addresses crisis centers, is the closest thing to what he's talked about being successful for these patients and people that work in that community that I've seen. It's pretty exciting. So, it introduces terms like the “central milieu area” which is new to us, and you know, has the code touch of telling you sizes and requirements, and everything's there, but what I'm excited about is there's a real lens for this patient population within the *Guidelines*.

[00:12:44] **Leah:** Yeah, you know, in my years working as a surveyor, I saw lots of different facilities all over the country, and it was always kind of sad to me to see some of these behavioral health patients being treated in emergency rooms where you had all of these risks with ligature and staffing was different, and then, because we had all these ligature risks, we had to be monitoring the patients all the time, even if they had to use the restroom, and I think that by creating these behavioral health crisis units, it provides those patients with a lot more respect and really the type of care that they need.

[00:13:19] **John:** Exactly because the emergency department is probably one of the noisiest and brightest parts of the hospital, and if you're experiencing a crisis, that probably is not the best place for many folks. I think the original concept in the hospital document was to be able to decompress the emergency room and move those behavioral health patients out of the acute care setting into one that's more sensitive for them.

But in 2026, you can do that not only in a freestanding emergency department but also just as a freestanding crisis behavioral health [center]. So, that's a way for the community, or EMS even, to intervene before they even make it to the acute care side and deliver folks directly to a behavioral health center readily equipped to deal with that particular intervention that they need.

[00:14:06] **Bridget:** Yeah, and that was a chapter that the committee, the revision committee, worked really hard on, making sure that they had the right people at the table to have those discussions because just as you said, John, [the 2026 edition] divides crisis centers into two separate things within the chapter.

So one of them is freestanding emergency department crisis centers, and then the other is community-based behavior health crisis centers, and they have different requirements in it, so I can't wait to see what the reaction is of folks that are maybe looking at this for the first time and what kind of feedback they might have during the comment period.

[Three bass note, jazzy musical interlude.]

[00:14:40] **Bridget:** So, those are three things that we all talked about that we're interested in personally. What other things are you going to be covering during your presentation while you’re here [at the 2024 Health Care Facilities Innovation Conference]?

[00:14:49] **John:** Oh, I've got one. This is one that I get asked at least four or five times a year: “What is the requirement for signage above your emergency department on the exterior of the of the building?” So, If you imagine driving up to a hospital, typically you will see a big sign that says “emergency” and that's where you know to go if you're having, you know, an emergent event, and people always ask me, “Are there requirements for that? For what that sign looks like? How big it is? Where it's located? How it's placed?” And for years, I've never been able to find anything other than maybe really jurisdictional specific requirements, like within a state. Have you, Leah?

[00:15:30] **Leah:** Yeah, you know, there was a bunch of changes that were made to [the *Guidelines*] in the last cycle, and it's a really interesting story how those changes came about. There was a tragedy that happened in Massachusetts a few years back where a woman, her name was Laura, was having a[n] asthma attack, and she tried to get help at a local hospital and was not able to get into the building. She went to an entrance to the emergency room, and the door was locked, and tragically she passed away. But what's interesting about this is her husband, who was a reporter with the Boston Globe, in her honor took that story and took it to the public and wrote about this tragedy that occurred, and through those efforts was able to get a law passed in Massachusetts called “Laura's Law.” And it addresses the physical environment types of things that we can implement in emergency room entrances to help address an issue like that. And so, within the 2022 document, we have some of those, and there have been more proposed for the 2026 document, but they really aim at making sure that patients that are in need of help can get that help.

You know, for a long time, we've talked about workplace violence and controlling access to our facilities, you know, keeping them locked, which makes a lot of sense for a lot of reasons, but when we do that, we have to make sure that we're not preventing those who need help from getting into the facility to get that help.

[00:16:57] **John:** Exactly. So, those were additions in 2022. In [the] 2026 [draft], we're going to see the requirement for an illuminated sign that says “EMERGENCY,” and it's [required to have] a contrasting background. So, that is the first set of directions I've seen to move people toward that location, that entry point.

[Three bass note, jazzy musical interlude.]

[00:17:18] **Bridget:** So, what else are you talking about for [the] 2026 [draft]?

[00:17:21] **Leah:** Well, I'm hearing a lot of interest in the medical and behavioral complexity patient unit. You know, we know that we have patients that are dealing with mental illness that also are in the hospital for other reasons. Maybe they had a stroke or a heart attack or whatever, and the type of environment that is suitable for them, given their behavioral health needs, is not your typical medical/surgical unit.

By providing some concrete requirements around that type of population, I think we can help answer a lot of questions to the community, you know, people just wanting to know, “What's the best way to treat those kinds of patients?”

[00:17:59] **John:** Yeah, because you not only have the behavioral health overlay, you also have the need for all the appurtenances, all the medical gas outlets, the electrical outlets, lots of different gear, and what is that sensitive kind of safe harbor approach to say, “All right, well this is an established way of being able to do this. If I design it that way, at least there's some level of predictability that an AHJ is going to look at that and say, ‘OK, you followed a *Guideline*. You’re all right.’”

[00:18:29] **Leah:** Right. Yeah, if it was just a behavioral health unit, we would have to deal with all of the ligature risks, the security risks, but we cannot get away from those when there also are medical needs, so having some kind of document to address that I think will be great.

[Three bass note, jazzy musical interlude.]

[00:18:48] **John:** I’ve got another one. In the outpatient book, we're finally addressing sleep centers, and these are the less than 24-hour stay sleep centers where you go in and you do a sleep study for, like, sleep apnea or some sort of sleep-related disorder. It's not a hospital bed, you're not staying there 24 hours, you're there for just a shorter period, you're sleeping, but typically I would see these in B occupancies. And when I would go in and try to apply an outpatient version of the *Guidelines*, and the overlay there, the rooms didn't always make sense because when we talk about exam room, which ostensibly this is just an exam room, a type of exam room, they're not big enough to put a bed in and not really big enough to be comfortable in, and it doesn't describe, like, a monitoring station or something like that. So now, rather than trying to read between the lines a little bit in the existing document and figure out a way to fit that into a regulatory scheme, there's going to be a chapter we can go to. It is a new chapter, right?

[00:19:48] **Bridget:** It is. It's chapter 2.16, and I'm excited about this chapter because it came about from a proposal. It was somebody outside of the revision committee that is interested in seeing the document address this type of facility and [she] put the proposal in, and then the committee took it, and they really spent time on it, getting it right, and comparing it to other sections in the document. And, so, that's out there for public comment, chapter 2.16.

[00:20:12] **John:** And that's an example of the process working; somebody raising their hand in the community and saying, “Holy cow, can we try something different? Can we get to a better solution?”

[Three bass note, jazzy musical interlude.]

[00:20:22] **John:** Another one we can talk about is two different sets of proposals that deal with two different types of discharge units inside of a hospital. One of the things that I certainly remember over the past couple of years is just challenges with folks who are either discharging and needing to either go home or get to another post-acute kind of facility, and those patients kind of stacking up in a hospital, and really preventing truly acute patients from finding a bed or finding a location, and there are two proposals in [the 2026 draft] that look at two options of decompressing that inpatient space.

So, the first is what I would call a “discharge lounge,” and this is for patients who are truly discharged, they're no longer inpatients, and there's a lot of conversation around what that means when you're not a patient and when you're not an inpatient anymore, but these are folks who would have had an acute care stay, an overnight stay, and they're ready to go home. Maybe they're waiting on a ride, maybe they're waiting on medication or a final set of paperwork, or something like that. There aren't any real true acute medical needs anymore, so, really this is a place for them to sit and wait for that connection back home.

Another type is, and I don't remember how we describe this, Bridget, but it's like a transport lounge?

[00:21:49] **Bridget:** Mm-hmm, the external transport discharge unit?

[00:21:51] **John:** There you go. And this is where maybe you have an acute care patient who is no longer in need of acute care. They're being transferred to a post-acute unit, so that could be a skilled nursing facility, it could be a long-term care rehabilitation type facility or a behavioral health type facility. And if we can find an appropriately safe and sensitive way to handle those patients, that again will clear up those acute care beds and make more space for people who need that acute care.

[Three bass note, jazzy musical interlude.]

[00:22:26] **Bridget:** So, we've got some other kind of heavy hitter changes, and I'm curious about the reduction of water age. That was a big thing in the code world.

[00:22:34] **Leah:** We've struggled with plumbing and waterborne pathogens in health care for a long time. For many years, the discussion was all about *Legionella*, which is one of our biggest concerns. We reference the ASHRAE 188 standard when it comes to *Legionella* risk, but there was a recognition that that's not the only waterborne pathogen that we deal with, and so, there have been some new standards that have been developed to address other types of pathogens, which I think we have a great opportunity within FGI to reference.

You know, the ASHRAE group really consists of a lot of experts when it comes to mechanical engineering, and they really have a lot of expertise on those subjects, but we still have to deal with health care-specific water age because the longer water sits in a pipe and it's stagnant, at a certain temperature, the more pathogens you're going to have growing, and so we need to design our facilities in a way to reduce that. And there's many different ways you can control it, one of which is appropriate piping size and eliminating dead legs within your piping system. So, I think it's great that FGI is going a little bit beyond some of the other standards that are out there to address that specific to health care.

[00:23:46] **John:** And it's a really interesting one, too, because when we look at some of the things you mention like piping size and dead legs, there's always that question of well, we have a plumbing code, and we have a number of different plumbing standards out there. Where is the point where we come in health care facilities and say, “OK, you need to do something dramatically different than you would in your general office building or convention center or home or what have you.” And that's either because of the particular risk that you see inside of a building or the particular occupant type that you see inside of a building—so, sort of charting that line of when do we go above and beyond the basic plumbing code is an interesting one, a fascinating one, to hear the discussion about over the cycle.

[00:24:32] **Bridget:** We've got new language in the draft that addresses medical device processing water distribution. That's a mouthful. But this one, we reference the AAMI Standard 108.

[00:24:44] **Leah:** Yes, AAMI 108 is a brand-new standard. It was, well, I should say it's brand new as a standard; it's been in existence for a while now as more of a guideline, but it was renamed as a standard here recently. One thing that I see with that proposal that I find a little bit concerning is it requires a separate water system for a medical device processing, which is not a requirement of that standard, and so, I want to make sure that as we develop these FGI proposals, we're not going beyond the intent of the reference without some kind of justification for that.

[00:25:22] **John:** Some of the conversation that I remember when talking about that particular standard is, if I recall, there's part of the standard that is built-specific, so it's about the building science and how you put a system together, and some of it is about how you operationalize that, and that is really kind of a traditional line that FGI has avoided crossing [is] moving into those operational requirements. When you look at the *Guidelines*, we are all about how you put the building together, and we try to avoid directing folks on how to operationalize it or implement it. So, [I’m] curious to see what folks have to say about that.

[00:25:58] **Leah:** Yeah, I think that applies to a lot of the proposals that we're looking at for this cycle, especially the plumbing ones. You know, there's a lots of different ways you can deal with water age in a building, and flushing of a system is just one type of mitigation. There are proposals that have been put forward that talk a lot about installing additional valves and different things for flushing of the system, and I think we need to be careful that we're not pigeonholing an organization into doing one specific thing when there are other mitigation options that are out there.

Other ways you can deal with water age is, you know, chemical disinfection. Obviously, the best thing you can do is to control the temperature of that water and keep it moving so that it doesn't become stagnant. That's done throughout health care facilities, but it's just kind of those end legs that we have that go from the main piping system to each individual fixture where we have a concern.

There was an interesting proposal that was put forward in FGI to require patient room sinks and toilet rooms to be on the corridor side of the patient room rather than be [placed] outbound on the exterior wall of the building, and the reason why that was put forward was to eliminate some of that length that you have from the main piping system to those fixtures within that handwashing sink or that toilet and shower and sink in the patient room bathroom.

You know, obviously, when it comes to patient room layout, we want to do what's best for the patient and the caregivers, and so there was a lot of discussion about whether we should mandate that, if that's the best for patient care, but I thought it was a really interesting discussion. [Note: That proposal ultimately was not accepted and therefore does not appear in the 2026 draft.]

[00:27:33] **John:** Mm-hmm. We don't want to limit that flexibility because having inboard toilets could potentially limit observation and visibility and that access to the patient from really what is the staff side of things, so I think we have a reasonable balance and, you know, the different ways of delivering piping and eliminating some of those minimum non-recirculated fixture branches, you can do with a lot of different approaches, but it changes the way the plumbing engineer looks at the building. I'll be curious to see where, you know, what the input is from different folks on those proposals that made it.

[00:28:09] **Leah:** Yeah. One thing we've been talking a lot about within ASHRAE is piping size. You know, we have jurisdictions that are mandating the use of low-flow fixtures within facilities, and what we're finding in health care is that given the way we normally engineer our piping size, we're ending up with all of these water age issues because we're using low-flow fixtures, and so, there's a lot of discussion happening right now about how to engineer the piping size so that you can use those low-flow fixtures and not have that issue with water age.

[00:28:41] **John:** One of the guiding stars of FGI for many years is acknowledging there are so many different ways that you can put a building together and giving people either a constraint or a set of options to be able to implement it because as we all know, you can design a hospital millions of different ways and be successful. The impact that it has on operation, of course, would be different in each of those million different designs.

[Three bass note, jazzy musical interlude.]

[00:29:08] **Bridget:** Can we give the residential document a little love for a minute? I just want to make sure that folks are aware and that we get eyes on the residential draft. It's got a few new things in it. There's dialysis treatment areas for nursing home residents—that's new. The resident room capacity is new. It's going to be a single patient room, is what we're looking at, in certain areas.

[00:29:31] **John:** Yeah, yeah, that is a pretty significant change. If folks remember from the emergency conditions work that FGI worked on during the pandemic, there was a recommendation out of that to consider going to single resident rooms inside of residential care facilities, and while that didn't make it into the 2022 *Guidelines*, that was a proposal that got some traction in the 2026. It's not across the board [that] every room is [required to be a] single patient room because there are cases where families are living together, people choose to live together, but it looks at making that a driving consideration for many of the rooms.

[00:30:11] **Bridget:** It's a minimum of 80 percent is what the draft language is, is single patient rooms, in nursing homes, assisted living, long term substance abuse, and um, IIDD, intellectual...

[00:30:24] **John:** Individuals with intellectual...

[00:30:26] **Bridget:** ...developmental

[00:30:27] **Leah:** Individuals with intellection and dis, dis...ability disorders. [Is] that right?

[Wah-wah sound indicating a wrong answer.]

[00:30:34] **Bridget:** Man, did we stumble over that one. It's Individuals with intellectual and/or developmental disabilities. Chapter 4.4 in the residential document.

[Ascending bell sound indicating a correct answer.]

[00:30:47] **Bridget:** There's some focus on the setting and household types, the dining area size.

[00:30:52] **John:** The dialysis area discussion is a good one because I think we've seen a QSO letter from CMS over the past couple of years that acknowledges the value of not sending residential care folks outside of that particular setting to receive their dialysis care, but creating a spot for it inside of the building, and this is just a description, a clearer description, that operationalizes that and gives folks a way to go, “All right, this is how you could do it,” and be compliant with a, you know, what often becomes a licensing rule.

[Three bass note, jazzy musical interlude.]

[00:31:25] **Bridget:** This is a new one. Have you seen this in the outpatient document? It's for the clean supply room. We've put language in there that says that it can be an area instead of a room based on the functional program.

[00:31:37] **Leah:** Is that specific to an operating room?

[00:31:39] **Bridget:** Throughout the document, anywhere where it mentioned clean supply room now says can also be an area.

[00:31:46] **Leah:** That's an interesting one because there are air flow considerations that need to be taken into effect anytime you're storing clean supplies.

[00:31:53] **Bridget:** So, that was brought up, but where they landed was that clean supply could be an area because as I understand that, sometimes it's like a cart with pre-sealed things, but the soiled supply room does not have an area option.

[00:32:06] **Leah:** Sure. Yeah, that makes sense because with soiled it would be a negative pressure room. With clean, you know, the devil's gonna be in the details because it depends [on] what that clean storage is. Is it sterile packs? Then they should be in a positively pressured room with appropriate temperature and humidity.

[00:32:23] **John:** If it's an extra box of gloves, that can be in your cabinet, in your exam room.

[00:32:27] **Leah:** **Leah:** Exactly.

[00:32:29] **Bridget:** So, it goes back to having the right people in the room when you're having the discussion and making those design decisions. Interesting. Well, I want to see what people say about that.

[Three bass note, jazzy musical interlude.]

[00:32:40] **Bridget:** We've talked about a lot of changes that are going to show up in the draft document. There are many more than what we spoke of. There were over 1,400 total proposals submitted and they were pretty evenly divided as far as the three documents.

[“Skip to My Lou” by Neal Caine Trio begins.]

[00:32:55] **Bridget:** Seventy percent of those proposals made it through this first round into the draft. This is the time to take a look at it here between now and September 30, 2024. That’s when the comment period ends. We appreciate you being part of this revision process. Leah Hummel, we appreciate you, too. Thanks for being with us today.

[00:36:16] **John:** Thank you so much.

[00:33:17] **Leah:** Thank you.

# **Outro**

[“Skip to My Lou” by Neal Caine Trio continues.]

[00:33:21] **Bridget:** Thanks for joining us for another episode of *Between the Lines with FGI*. Do you have an idea for an episode or a question that you'd like us to answer? Please get in touch by writing to us at podcast@fgiguidelines.org.

[00:33:35] **John:** Also, if you're interested in becoming a sponsor for one or a series of episodes, you can reach out to us at the same address. It is podcast@fgiguidelines.org.

[00:33:46] **Bridget:** Many thanks to Neal Caine and the Neal Caine Trio for the use of his song, “Skip to My Lou.” You can find it on the album of the same name.

[00:33:55] **John:** Join us next time as we go between the lines with FGI. Bye, everybody.

[Music continues.]

[00:34:05] **Bridget:** All right, John, pack up. Time to go back to Washington State.

[00:34:08] **John:** Woo-hoo!

[00:34:09] **Bridget:** Home of the...evergreens? The pines? The fir trees. You have a lot of trees.

[00:34:15] **John:** Fighting clams.

[00:34:16] **Bridget:** Clams?

[00:34:17] **John:** The Fighting Clams. Evergreen State University, they're fighting clams.

[00:34:20] **Bridget:** That's amazing. I'm going back to toasted ravioli, the arch, and a lot of Chuck Berry music.

[00:34:26] **John:** I don't know that Evergreen State is actually the fighting clams; they might be the geoducks [pronounced *gooey ducks*], so...

[00:34:31] **Bridget:** I’m sorry, what?

[00:34:33] **John:** “Gooey-Ducks.”

[00:34:33] **Bridget:** Here’s something we have in common. Do you know St. Louis is famous for gooey butter cakes? Not gooey butter duck cakes, but just gooey butter cakes. Have you had those before?

[Conversation trails and fades.]

[Music continues then fades.]

[00:34:59] **Episode ends.**