ASHE 2014 Advocacy Report

An update on the quest for responsible regulation of health care facilities

Working to create up-to-date codes and standards that don't conflict with other regulations

Resources to keep your hospital in compliance

How you can help improve codes and standards regulating hospitals

American Hospital Association®

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A personal membership group of the American Hospital Association

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The American Society for Healthcare Engineering (ASHE) is a personal membership group of the American Hospital Association. More than 11,000 members rely on ASHE as a key source of professional development, industry information, and advocacy, including representation on key issues that affect their work in the health care physical environment. For more information about ASHE, contact 312-422-3800 or visit www.ashe.org.

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Letter to Readers

The physical environment of a health care facility is often overlooked as an integral part of patient care. Highly specialized medical and life safety systems keep patients safe and provide clinicians with the tools they need. The health care physical environment affects patient satisfaction and overall comfort—and even a patient's perception of pain. Even the most basic health care facility, such as a mobile army surgical hospital, includes complex systems to create an environment that supports successful medicine. Every health care building is a custom design requiring contributions from a mix of many different trades.

The codes and standards that regulate the complex health care physical environment were created to keep patients safe. Over the years, these codes expanded and overlapped with other requirements, and now hospitals often find it difficult to comply with all the regulations without wasting valuable resources.

Four years ago, ASHE embarked on a journey expected to be difficult and long—a journey to "unify" the hospital construction and life safety codes. Our thinking then—and today—is that if the decisions made in creating construction and life safety requirements are backed by good science, defensible economics, informed policy-making, and clear decision authority then all of the regulations should come to the same conclusions, thus creating similar if not exactly the same requirements.

To date, this has not been the case. However, out of the hundreds of conflicts between the various codes and standards that apply to health care, we are happy to report that as many as 80 percent of these conflicts have been resolved through advocacy efforts in recent years. Our robust advocacy program set the stage for the nation's top experts to come together, analyze the issues, and resolve many of the differences between the codes.

While regulations will always be a critical part of keeping patients, staff, and visitors safe, current codes and standards still leave much room for improvement. ASHE is working to improve outdated codes, conflicting codes, codes not based on science, and inappropriate code interpretations.

The codes and standards regulating the health care physical environment are written and published by third-party nonprofit organizations on regular development cycles, often within American National Standards Institute (ANSI) rules for consensus standards development. The ANSI process ensures that anyone with a material interest in the outcome of a document has an opportunity to propose and review intended changes. The revision cycle allows the codes and standards to evolve with emerging technologies and address lessons learned from various situations.

Codes and standards are adopted by federal agencies as well as state and local entities. Currently, many states adopt different editions of the codes adopted by the

federal agencies, and cities or counties may adopt yet other editions of the same codes. In some projects, a hospital may have to comply with editions of the same code published in 1999, 2005, and 2012. It is important that we work toward more unified adoption of current codes.

Changing codes to reduce conflicts means nothing if agencies don't adopted the updated codes. The Centers for Medicare & Medicaid Services (CMS) typically waits about 14 years to update their references to codes and standards. In that time, so many critical events can happen to change the standards. For instance, in the last 14 years, many events have changed the way we design and construct buildings. The Sept. 11, 2001, terrorist attacks on the World Trade Center led to a review and updated codes for how we design high-rise structures and evacuate occupants in emergencies. Other events—including hurricanes Katrina and Sandy, the 2003 power blackout in the Northeast, and tornadoes in Joplin, Mo., and Moore, Okla.—have also spurred code changes. But until CMS adopts the latest edition of the *Life Safety Code*®, hospitals must comply with the 2000 edition written before any of these events occurred.

New, updated codes do not equal increased costs. As a matter of fact, many of the code changes reduce either capital construction costs or operational costs for facilities. Regardless of cost, these revisions often have a direct impact on the quality of patient care. It is imperative that we use the latest, most up-to-date information and technology as we care for our patients. To support this, ASHE is committed to advocating for code changes that reduce the number of conflicts, are up to date, and are based on science.

We hope this Advocacy Report helps convey our messages about codes and standards and encourages ASHE members to get involved. By working together—and working with code-writing organizations, state and local agencies, and the federal government—we can ensure the latest editions of codes and standards are adopted so that hospitals can focus on patient care and not the burden of complying with conflicting, outdated codes.

Sincerely,

Chad Beebe, AIA, SASHE
ASHE Deputy Executive Director of Advocacy

Who is ASHE?

The American Society for Healthcare Engineering (ASHE) is the largest association devoted to optimizing the health care physical environment. ASHE is a personal membership group of the American Hospital Association and has more than 11,000 members. ASHE members design, build, and operate hospitals. Our members are involved in improving the health care physical environment from the time hospital plans are drawn throughout the lifespan of a hospital.

Members rely on ASHE for continuing education, professional information, and advocacy efforts focused on pushing for up-to-date, science-based codes and standards that keep patients, staff, and visitors safe.

ASHE members include:

- Architects and other design professionals
- Contractors
- Facility management professionals
- Consultant engineers
- Clinical and biomedical engineers
- Health care construction managers
- Infection preventionists
- Maintenance engineers
- Plant management services personnel
- Safety and security professionals
- Support services personnel

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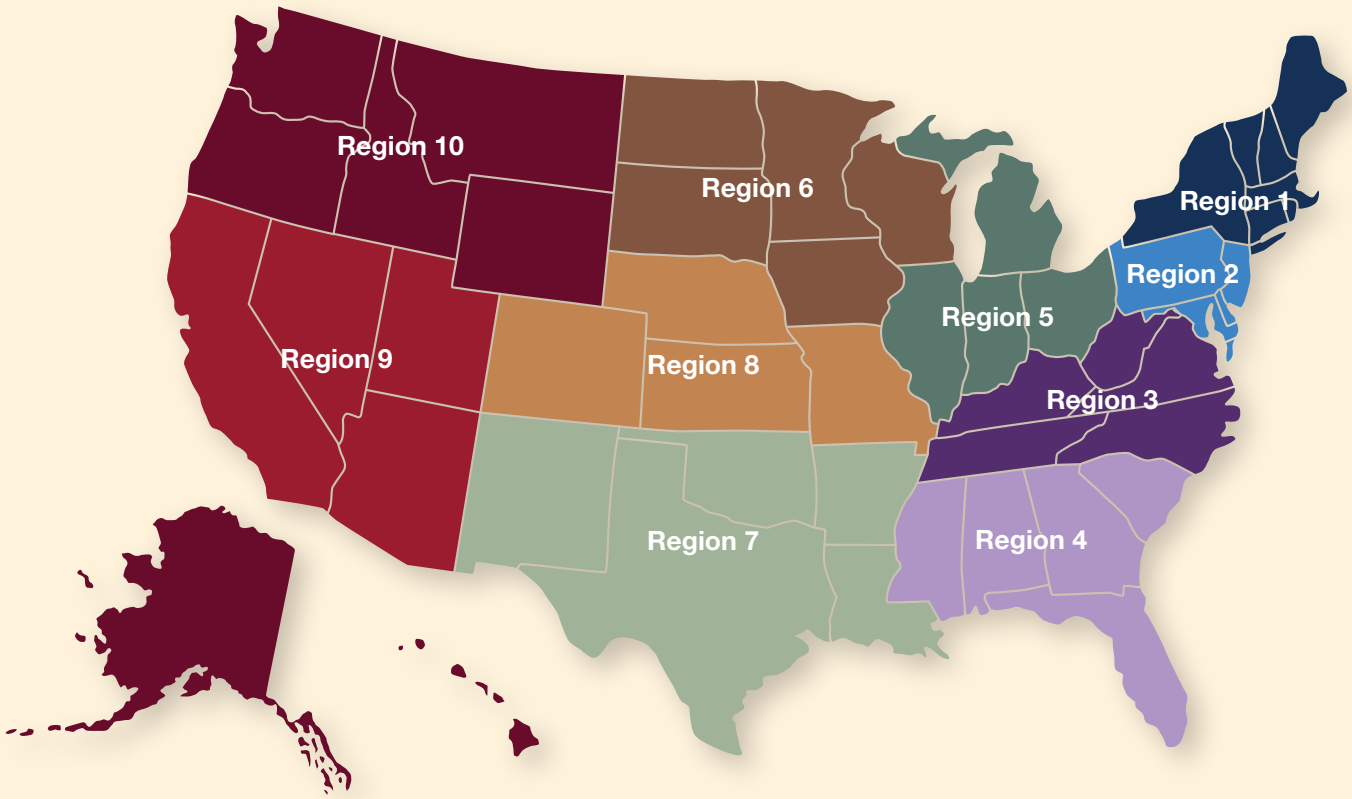

ASHE uses a committee structure of volunteers to help carry out directives from the Board of Directors. ASHE committees work on advocacy, education, chapter relations, and membership issues. ASHE's Advocacy Advisory Committee includes experts who work to advance the codes and standards that affect hospitals. The Advocacy Advisory Committee includes:

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Working for better codes and standards

By Deanna Martin
ASHE Communications Manager

Hospitals are unique environments. They operate around the clock and encompass a variety of activities, from diagnostic and treatment functions to food preparation, business operations, and community services. They include complex medical systems not found in other buildings and house vulnerable patients, requiring additional precautions for life safety.

Because of all these factors, hospitals are heavily regulated environments—subject to requirements from more than 25 state and federal agencies. As part of its mission to optimize the health care physical environment, ASHE works with everyone involved in codes and standards—including code-writing organizations considering new proposals, federal and state agencies adopting codes and proposing rules, and ASHE members working to comply with numerous codes and standards. ASHE's advocacy team uses collaboration and communication to advocate for better codes and standards on behalf of hospitals and patients.

Codes and standards regulating hospitals have been around for decades. In 1918 the American College of Surgeons began inspecting hospitals using a single-page document called "The Minimum Standard for Hospitals." In 1946 the Hospital Survey and Construction Act, often referred to as the Hill-Burton Act, was created to improve the country's health care infrastructure. Multiple codes regulated the health care environment, including those focused on building requirements and others focused on life safety. In 1965 the federal government established the Centers for Medicare & Medicaid Services (CMS), and code compliance was tied to reimbursement for Medicare and Medicaid programs.

ASHE currently works with many code development organizations to help create facility requirements that will protect patients and staff while avoiding code conflicts and unnecessary regulations. ASHE staff members are members of several National Fire Protection Association (NFPA) technical committees that develop codes such as NFPA 101: *Life Safety Code*® and NFPA 99: *Health Care Facilities Code*. ASHE attends NFPA meetings and encourages members to do the same because NFPA technical meetings are a chance to speak up about potential code changes.

ASHE worked with the International Code Council (ICC) to create the ICC Ad Hoc Committee on Healthcare. The committee—a diverse group that includes fire officials, architects, building officials, hospital leaders, facility managers, and engineers from around the

country—is taking a fresh look at current codes in light of modern health care practices. The group, which includes ASHE staff and volunteers, recommends appropriate updates to the International Codes.

"This is really a groundbreaking opportunity for health care professionals to work side by side with code enforcement officials to collectively craft codes that address the unique needs of health care facilities," said ASHE Senior Executive Director Dale Woodin, CHFM, FASHE. "We are thrilled by the committee's use of research and data to support code changes and to determine the optimal level of safety."

ASHE is also involved with the Facility Guidelines Institute (FGI), which produces the *Guidelines for Design and Construction of Hospitals and Outpatient Facilities*. ASHE Deputy Executive Director of Advocacy Chad Beebe, AIA, SASHE, is a member of the FGI Health Guidelines Revision Committee Steering Committee, which helps shape the *Guidelines*.

In addition to working with organizations creating codes and standards, ASHE works to get updated codes actually adopted nationally and in states.

For example, ASHE has developed a close working relationship with CMS that has led to increased communication and a better understanding on the part of CMS of the unique requirements of the health care physical environment. When CMS considers new regulations, ASHE submits public comments and urges its members to do the same.

ASHE is also a member of the Coalition for Current Safety Codes, which aims to create more public awareness and broader support for the adoption of up-to-date codes and standards. This group, co-chaired by NFPA and ICC, is open to nonprofit organizations, local governments, code officials, industry leaders, schools, and concerned individuals. To join the coalition or learn more, visit www.coalition4safety.org.

ASHE's advocacy team also works with state agencies to promote the adoption of current codes. The team writes letters urging code updates and can help ASHE members get appropriate codes adopted in their own states.

Of course, another major component of ASHE's advocacy program is working with members to help improve compliance with the various codes and

standards regulating hospitals. Compliance with CMS requirements is critical as Medicare currently accounts for 41 percent of hospital revenue on average, and Medicaid makes up another 15 percent, according to the American Hospital Association. That means about 55 percent of hospital revenue comes from government sources. Even facilities that do not participate in CMS reimbursement seek private accreditation to show their commitment to health, safety, and quality.

ASHE offers several resources for compliance help. ASHE's advocacy team often travels to local ASHE-affiliated chapters to speak about code compliance issues. Staff members speak at annual conferences to update members on new requirements coming down the pike. ASHE also uses its Advocacy Highway—a two-way means of communication—to work with advocacy liaisons in affiliated chapters on codes and standards issues.

In addition, the Just Ask ASHE service allows members to submit code questions and get answers from subject matter experts. The article on page 34 explains more about the advantages of this service. ASHE members also gain access to monographs, publications, news articles, and advocacy alerts to help them stay up to date on code issues.

By working in all stages of the code process—from proposal to compliance—ASHE's advocacy team strives to promote better regulations for health care facilities. But ASHE needs your help to further improve codes and standards. See the story on page 37 about how you can get involved, or flip to page 44 to see a summary of ways to participate in the quest for responsible codes and standards.

Portions of this article were written by Lynn Kenney and first appeared in the 2013 ASHE Advocacy Report.

Smoke compartments: Why 40,000 square feet makes sense

By Jeffrey T. O'Neill, AIA, ACHA
Director of Engineering Services, Pennsylvania Hospital, Penn Medicine

Smoke compartments are an important part of keeping hospital patients, visitors, and staff members safe. Recent health care design and technological advancements have contributed to the trend toward larger patient rooms, but smoke compartment regulations have not been updated to reflect this shift. ASHE is working with code organizations to promote larger smoke compartment maximums to accommodate modern needs without diminishing patient safety.

As of May 2014, the maximum size for smoke compartments in hospitals is 22,500 square feet according to the major building codes, including the *International Building Code* (IBC), *International Fire Code* and NFPA 101: *Life Safety Code*—although it is important to note that the 2015 edition of the IBC has been modified to increase the maximum size to 40,000 square feet.

The *Life Safety Code* calls for smoke barriers to "be provided to divide every story used for sleeping rooms for more than 30 patients into not less than two smoke compartments. The size of any such smoke compartment shall not exceed 22,500 square feet, and the travel distance from any point to reach a door in the required smoke barrier shall not exceed 200 feet." Changing this regulation to 40,000 square feet maximums for smoke compartments—and making the change in all codes regulating health care facilities—would meet hospitals' needs for additional space to treat the same number of patients with the same number of staff, thus not increasing the occupant load.

Regulation history

Smoke compartment regulations are found in multiple codes, where they have developed in similar ways over time. The regulations stem from requirements for maximum travel distances—the maximum length of space a person must travel to move to another smoke compartment in the event of a fire or other emergency.

The 1967 edition of the *Life Safety Code* required a maximum travel distance of "150 feet of corridor length" to get to a "smokestop partition." Some say that the travel distance requirement was determined based on the number of footsteps for a nurse to reach the barrier, and others claim it was determined based on the length of a fire hose, while still others say the length represented how long someone can travel while holding their breath. It should be noted

Hospital compartments must have travel distances of no more than 200 feet to reach another smoke compartment.

that the code at that time had no square footage requirements for smoke compartments.

By the time the 1985 *Life Safety Code* was published, the 22,500-square-foot requirement was added as a logical interpretation of the travel distance translated into area (150 feet x 150 feet = 22,500 square feet).

The regulation developed in the International Codes in much the same way. Smoke compartment regulations stemmed from the Building Officials and Code Administrators (BOCA) code of the 1960s and 1970s, which eventually fed into the International Codes. In 1984 the Board for the Coordination of the Model Codes required a maximum travel distance length and width of 150 feet. Then, in 1992, BOCA implemented the 22,500-square-foot maximum for smoke compartments with a maximum travel distance of 150 feet.

As hospitals and codes placed an increased emphasis on sprinklering, the maximum travel distance in the *Life Safety Code* eventually increased to 200 feet when a compartment is fully sprinklered. The requirement for new health care construction to be fully sprinklered was introduced in the 1991 edition of the *Life Safety Code*. This requirement remains as a condition for using the larger size smoke compartment. The 1996 BOCA code also allowed for maximum travel distances of 200 feet, as do the modern International Codes, which were developed in part from BOCA requirements.

Each of the major codes currently allows a maximum travel distance of 200 feet for fully sprinklered facilities. But as the maximum travel distances have increased over time, the maximum smoke compartment size has remained the same. ASHE believes the current travel distance of 200 feet is reasonable and does not need to be changed. However, ASHE supports proposals to increase the maximum smoke compartment size to 40,000 square feet, which simply reflects the logical maximum compartment size based on the 200-foot travel distance (200 feet x 200 feet = 40,000 square feet).

ASHE successfully worked with the International Code Council to modify the 2015 edition of the IBC to increase the maximum smoke compartment size to 40,000 square feet. Other codes should make this change as well to provide unified and modern regulations for health care facilities.

Changes in patient care areas

Full sprinklering is not the only fire safety advancement of the last 40 years that supports the reasonableness of a 40,000-square-foot smoke compartment. The layout of the patient room has changed significantly. At the time the concept of the smoke compartment was introduced, many hospitals still had open inpatient wards. In some cases, as many as 16 medical or surgical beds existed in one open ward. In the 1970s and 80s, this changed to about four beds per room. Two-bed rooms were standard in the 1990s, and the current standard is a single-patient room. A single-patient room has a door and smoke-tight wall between patient and corridor. Combined with suites, the level of compartmentalization within a smoke compartment has significantly increased, especially in relation to the protection of individual patients.

Recent decades have also seen a steady increase in the size of patient treatment rooms in hospitals. The primary reason for this increase is the additional equipment and utilities necessary for the treatment of a patient, such as equipment for monitoring, medical gases, and diagnostics. In response to this trend, requirements in the widely adopted *Guidelines for Design and Construction of Hospitals and Outpatient Facilities* from the Facility Guidelines Institute have also increased space requirements, making these operational considerations actual code requirements.

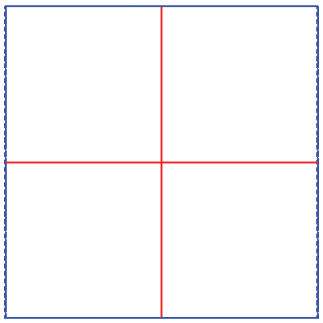
The concept of an "individual patient space" is becoming the standard design in areas throughout the hospital. Instead of open areas with cubicle curtains, many emergency departments are opting for private patient exam spaces with hard walls, primarily for infection control and patient privacy considerations. Similarly, radiology areas are driven by technology and clearance issues that go beyond required minimums and affect the square footage needed to achieve clearances. Some units have seen an increase in the types of required support spaces, including ratios of equipment storage per treatment room, the increased importance of computer equipment rooms, and the need for various staff areas; however, space requirements for support spaces have remained largely the same. While the size of patient treatment areas has been increasing, the smoke compartment size requirements have been left unchanged in the building codes.

The larger space requirements of functions such as emergency departments, radiology operations, and nursing units allow for greater visualization from the staff to the patient, which is a crucial aspect of planning a patient area. This operational consideration requires an increase to the smoke compartment size to match contemporary patient care areas requirements, delivery of care, and use of technologies. In short, today's hospitals need more square footage to care for the same number of patients. These changes demonstrate the need to increase the maximum smoke compartment size to 40,000 square feet.

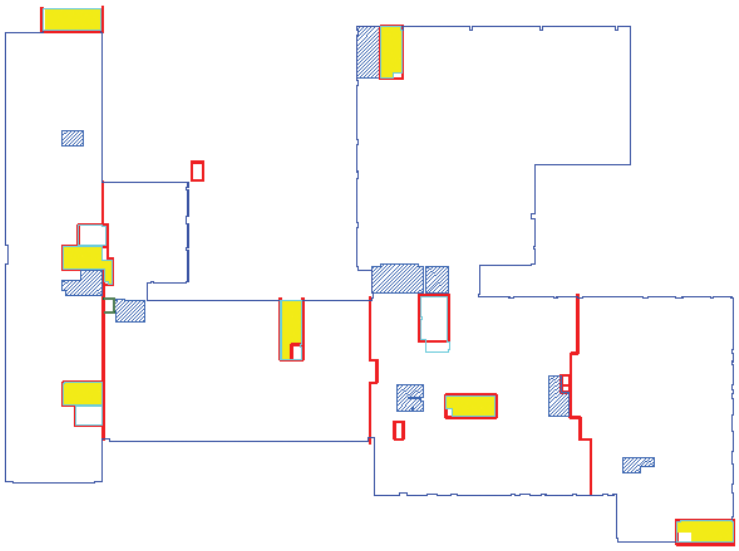
ASHE's advocacy group recommendation

From a planning perspective, hospitals will continue to be designed by program first and smoke compartment size second. This hierarchy reflects the necessary functional relationships mandated by code and important to the operations of a hospital. Not all smoke compartments are at today's maximum of 22,500 square feet, so it is unlikely they will all reach a maximum of 40,000 square feet. In fact, many smoke compartments measure 13,000 to 15,000 square feet simply because the zone must be split.

The requirement for two smoke compartments per floor is an important piece of the defend-in-place strategy, allowing for movement of patients horizontally on the same floor in the event of a fire. As patient rooms, operating rooms, and imaging suites continue to require more space to accommodate advancing technology and proper circulation, the 40,000-square-foot smoke zone maximum is a necessary allowance that will not jeopardize patient, staff, and visitor safety.



Smoke zones are NOT laid out in perfect squares as shown. Such a design is impractical and violates the requirement for a 200-foot maximum travel distance.



Smoke zones are laid out considering the building envelope, site constraints, and—most importantly—functional program requirements and key adjacencies. The ASHE advocacy team's proposal maintains a minimum of two smoke compartments per sleeping floor.

Revamping codes to protect patients—and resources

By Jonathan Flannery, MHSA, CHFM, FASHE
Senior Associate Director of Advocacy, ASHE

If you've ever been to a hospital as a patient or visitor, you've no doubt paid close attention to the medical care you or a loved one received. But unless you are involved with hospital design, construction, or facility management, you may not have thought much about the health care physical environment—the humidity levels in operating rooms, the placement of smoke and fire dampers in smoke and fire barrier walls, or even the size and type of recycling bins.

Although often unnoticed, the health care physical environment plays a critical role in keeping hospitals and other health care facilities safe. This special environment is heavily regulated by various codes and standards enforced by local, state, and federal authorities. While regulations are a critical part of keeping patients, staff, and visitors safe, health care codes and standards have a lot of room for improvement. They are often outdated, not based on science, conflict with one another, or are poorly written, which leads to misinterpretation. Hospitals do not want to unnecessarily spend valuable resources on overlapping and conflicting codes, over regulation, unjustified code enforcement, and code misinterpretations. In the current economic climate, hospitals and other health care facilities are looking for ways to redirect resources to improving care for patients. By refining codes—and reducing code conflicts—hospitals have the potential to focus more of their valuable resources on patient care.

ASHE is a personal membership group of the American Hospital Association dedicated to optimizing the health care physical environment. More than 11,000 members rely on ASHE as a key source of professional development, industry information, and advocacy, including representation on key issues that affect their work in life safety and the environment of care. In 2011, ASHE established as one of its strategic initiatives a focus on unifying health care codes and standards. This initiative helped ASHE focus its many efforts to improve codes and standards for health care facilities and led to several key developments in the health care industry.

One of the most significant developments was a partnership with the International Code Council (ICC), the standards development organization that manages the ICC collection of model building codes. ASHE and the ICC recognize the problems stemming from inconsistent and outdated codes

and have partnered to create the ICC Ad Hoc Committee on Healthcare (AHC).

The committee, a diverse group that includes fire officials, architects, building officials, hospital leaders, facility managers, engineers, and other interested parties from around the country, was given the mission to "assess and amend the current ICC family of codes to ensure that these requirements are appropriate to the special safety risks that exist within hospitals and ambulatory surgery facilities."

Over the last three years, the AHC has recommended nearly 100 code change proposals to the International Codes, including the *International Building Code* and the *International Fire Code*, through the ICC code development process. These code proposals have not only been focused on making sure that ICC codes are appropriate to the special safety risks that exist in hospitals and ambulatory surgery facilities, but have also been focused on helping to unify the ICC code requirements with those of other health care codes and standards used to manage life safety and the environment of care in hospitals.

"This has really been a groundbreaking opportunity for health care professionals to work side by side with code enforcement officials and industry interested parties to collectively craft codes that address the unique needs of health care facilities," said ASHE Senior

Although often unnoticed, the health care physical environment—and the codes that regulate it—play a critical role in keeping patients safe.

Executive Director Dale Woodin, CHFM, FASHE. "We are thrilled by the committee's use of research and data to support code changes and to determine the optimal level of safety."

Many ad hoc committee members hope the group's efforts are a first step toward the long-term goal of having hospitals designed, built, and operated under one set of uniform requirements. They eventually want to have a set of codes that do not conflict, are created using the best science available, and provide optimal levels of patient safety without burdening hospitals with unnecessary capital expenditures.

Having one set of requirements may not prevent misapplications of the codes, but it would help hospitals funnel resources to patients instead of wasting resources to comply with conflicting codes, said committee vice chair Jeffrey O'Neill, AIA, ACHA, director of engineering services at the University of Pennsylvania Health System in Philadelphia.

"That's why this process is so exciting to all of us," O'Neill said. "We'll always have our state departments of health, our local fire groups, and building plan review groups, but having them looking at the same book at least begins to have some consistency throughout what we're doing."

One of the significant changes made by the AHC is the alignment of the *International Fire Code* (IFC) with the National Fire Protection Association (NFPA) NFPA 101: *Life Safety Code*® (LSC). During last year's ICC code development cycle, the AHC submitted several proposals that helped align the 2015 edition of the IFC with the 2012 edition of the LSC. It is estimated these proposals will significantly reduce health care construction costs by preventing conflicts between these two important codes.

A key goal that remains for ASHE is to advocate for the adoption of these new codes by the appropriate authorities having jurisdiction. For example, the Centers for Medicare & Medicaid Services (CMS) currently requires hospitals to comply with the 2000 edition of NFPA 101. Since the 2000 edition was published, a total of four updated editions of that code have been released—in 2003, 2006, 2009, and 2012. CMS is currently considering adopting the 2012 edition of the *Life Safety Code*, an action that could allow hospitals to funnel significant resources away from compliance with unnecessary code requirements toward improving patient care outcomes.

Codes issued in 2000 may not seem that old, but the edition of the *Life Safety Code* currently required by CMS was written before the September 11, 2001, terrorist attacks; Hurricane Katrina in 2005; Super Storm Sandy in 2012; and the Joplin, Mo. and Moore, Okla. tornadoes in 2011 and 2013, respectively. The 2012 edition of the *Life Safety Code* incorporates lessons learned in those tragedies and other events of the last decade.

In addition to improvements based on lessons learned from significant events, code development efforts have also focused on scientific bases for recommended improvements. An example of this process is the change in the requirement for relative humidity levels

within operating rooms. An exhaustive literature search by the National Institutes of Health (NIH) determined that no clinical benefits were obtained by the requirement to maintain a 35 percent minimum relative humidity (RH) level in ORs. This research allowed the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standard Project Committee to revise its ANSI/ASHRAE/ASHE Standard 170: *Ventilation of Health Care Facilities* to a minimum requirement of 20 percent RH. This change will allow for more resources to be redirected to improved patient care outcomes. Unfortunately, as mentioned earlier, because of regulatory processes within the Administrative Procedures Act, CMS is still in the process of adopting the latest version of the codes and standards which would make these updated standards applicable to hospitals. Through advocacy efforts by ASHE and others like the Joint Commission, CMS has identified several areas of the 2000 edition of the LSC and 1999 edition of NFPA 99: *Health Care Facilities Code* that may result in unreasonable hardship on hospitals because current editions of the codes permit alternative approaches that provide an equal level of protection.

CMS has been able to issue several categorical waivers over the last couple of years to allow hospitals to take advantage of specific improvements in the improved codes and standards. For example, through CMS Survey and Certification (S&C) Letter 13-58-LSC, hospitals are now allowed to test electric motor-driven pump assemblies (electric fire pumps) monthly instead of weekly and are allowed to increase the size of containers used solely for recycling clean waste or for patient records awaiting destruction outside of a hazardous storage area from a 32-gallon container to a container for up to 96 gallons. These two changes will also allow hospitals to direct more resources toward more pressing patient care or safety issues.

Through more recent advocacy efforts, CMS issued S&C Letter: 14-07-Hospitals that allows hospitals to use alternative equipment maintenance (AEM) methods to maintain medical equipment. If this AEM methodology allows hospitals to reduce unnecessary maintenance efforts by 5 man hours a week, it will allow hospitals to redirect approximately 1.2 million man hours each year to address more pressing patient safety issues like alarm fatigue.

Although significant improvements have been accomplished, ASHE's strategic initiative of a unified code for hospitals is still a work in progress that has a long way to go. By sharing a few of the specific recent accomplishments, ASHE can encourage greater participation in this vital initiative. The goal of creating streamlined, science-based codes and standards is a major undertaking that requires support from people in a wide variety of professional positions. ASHE encourages you to become more involved in the code development process by developing a collaborative relationship with your local building officials and authorities having jurisdiction. Creating opportunities for talking with potential advocates is an important step

in the advocacy process, said O'Neill. "Knowing advocacy contacts can be tremendously helpful," O'Neill said. "Conversations can help open up the door."

Another vital pathway for participation is the ASHE Advocacy Highway. The Advocacy Highway was created a few years ago as a two-way means of communication on advocacy issues, allowing local issues to quickly gain national attention when needed and allowing chapters to become more engaged in setting national codes and standards. To help collect information from around the country, ASHE has developed a page on its website (ashe.org/advocacyhighway) that people can use to inform ASHE about code interpretations and other advocacy issues affecting them. ASHE also urges local advocacy liaisons to engage with their local authorities and network with potential advocates.

Woodin notes that information ASHE collects from across the country helps support big goals such as more appropriate codes and standards. "This information helps build the case for uniformly applied and interpreted codes for health care facilities," Woodin said. "That accomplishment could potentially save our industry a huge amount of resources that could go toward hospitals' first priority—patient care."

Health care codes should strive for "minimum"

By Ed Avis
for ASHE

All your life you've been encouraged to strive for the maximum and be all you can be. But if you're writing codes for health care facilities, that's suddenly bad advice.

In that job, you should instead strive for the minimum because codes are intended to provide minimum standards, not best practices.

"Codes are typically minimum standards, and if you take a look back 50 or 60 years, you see that the scope then was exactly the same as today," said ASHE Deputy Executive Director of Advocacy Chad Beebe, AIA, SASHE. "But now the volume of the text has increased exponentially. Given that the scope of the codes hasn't changed, it makes you wonder: Why were we able to say things in so many fewer words then?"

There are likely many answers to that question, ranging from the possibility that those working on code revisions may want to contribute something to the code, to the fact that society is more litigious today, prompting some code writers to spell out every detail.

But Beebe said a major contributor to the ever-increasing code books is the disconnect between minimum standards and ideals.

"When you start digging into it, you find that we've started to develop standards around idealistic scenarios," Beebe said. "In the case of health care, we tend to think of an ideal hospital and say that's the minimum. Well that's the ideal, not the minimum. You tend to forget that you can provide great care in a desert in a war zone in a MASH tent. Somewhere between a MASH tent and an ideal hospital lies the hospital that meets the minimum standards."

Consider the example of staff resting rooms, commonly called nap rooms. Many hospitals use staff nap rooms, particularly if they are a teaching hospital where resident physicians work long hours.

"You may decide that providing an area for staff to get some rest is good for the safety of the patients, and works well with your staffing model," Beebe said. "But I don't believe that we should mandate that nap rooms should be provided for all hospitals."

The idea of maintaining minimum code language is on the minds of those involved in the code development processes of organizations such as the National Fire Protection Association, the International Code Council, and the Facility Guidelines Institute.

Many hospitals are creating staff resting rooms so physicians working long hours can rest. But are nap rooms a minimum requirement that should be part of every hospital?

For example, the Facility Guidelines Institute's Health Guidelines Revision Committee met in St. Louis in April 2013 to make final decisions on what would be included in the 2014 edition of the *Guidelines for Design and Construction of Hospitals and Outpatient Facilities*. The committee considers proposals submitted by members of the public, many of which extended beyond minimum requirements.

For example, one proposal suggested that a shower be required in each patient toilet room. Of course most patients would enjoy a convenient, private shower. But in reality it may not be practical, or needed, in every situation. It certainly is not a "minimum standard." The idea was struck.

Many other proposals addressed by the committee in St. Louis dealt with similar issues—things that would be nice to add to a hospital, but shouldn't be a minimum requirement. The argument ended in favor of minimum requirements most of the time.

Of course, these issues are not black and white. What seems like a minimum in one situation may seem extravagant in another. Sometimes the situation is exacerbated by external circumstances, such as changing demographics.

For example, the needs of bariatric patients was a frequent topic during the St. Louis meetings, and sometimes these discussions illustrated the fine line between minimums and ideals. Should all railings in stairwells be designed to handle 1,000 pounds of downward pressure? If a very large person leans heavily on a railing in a hospital stairwell, of course hospital staff want the rail to bear the weight. On the other hand, how likely is it that a person of that size will be using the stairs? And is the added cost of creating such a strong railing justified by the slim possibility that it will be needed?

Another issue affecting code minimums is differing opinions about whether requirements should be performance or prescriptive. If requirements are truly minimum standards, should the details be left up to designers and owners? Or do specifics make the minimum standards easier to follow and more predictable?

For example, one proposed change provided rather specific measurements for the required personal storage space in a patient room: "The storage shall have minimum clear dimensions of 1 foot 10 inches (55.88 centimeters) in depth by 2 feet 6 inches (76.20 centimeters) in width."

In contrast, the requirement regarding storage in a laundry facility simply says, "Storage shall be provided for laundry supplies."

Which of these is a minimum standard?

Is the requirement for the patient room better because there's no room for interpretation? Or is the laundry storage requirement better because it doesn't burden the designer with specifics that may not fit a hospital's situation? If requirements are more vague, how will a hospital or designer know they have achieved the minimum level of storage to obtain approval?

These types of questions, and the ways they get answered, will help shape code development in years to come.

"There's a national struggle right now about whether it's better to have best practices or minimum standards," Beebe said.

Health care facility managers are not the only ones affected by expansive codes. Jon Nisja, a supervisor in the Minnesota State Fire Marshal Division, said he's a big believer in fire and life safety codes.

"They have been very effective in saving thousands of lives over the years," Nisja said. "But in the past couple of decades the code process, in my opinion, has become too complicated and confusing."

Exacerbating the problem, Nisja said, is the fact that over time, fire code revisions have created contradictory requirements, requirements that have drifted from their original intent, and requirements that appear to benefit vendors more than fire safety.

"Most fire marshals, fire protection contractors, and building managers/engineers are not fire protection engineers,"Nisja said. "We rely on the codes to give us clear and concise answers that will provide a high level of fire and life safety for the people we protect."

Something similar can be said of hospital engineers and managers. They don't need codes that dictate design issues or ideal accoutrements for every patient room. They just need concise, easy-to-follow codes that help them create safe, effective health care facilities. They need the minimum.

Hurricane Sandy and other events show the need for updated regulations

By Jonathan Flannery, CHFM, FASHE, MHSA
ASHE Senior Associate Director of Advocacy

Major events—including natural disasters, terrorist acts, security threats, and fires—are unfortunately part of modern life. It's important for the codes and standards regulating hospitals to be updated regularly (and for the most up-to-date editions to be adopted) to incorporate emergency planning lessons learned from these tragedies.

In 2012 Hurricane Sandy caused 110 deaths. The storm destroyed or damaged more than 650,000 homes and left more than 8 million people without power. At least 23 states felt the direct effects of the hurricane, while millions of other Americans felt the indirect effects of the storm. Some of the direct effects of Sandy were:

- The subway system in New York City suffered the most extensive damage in its 108-year history.
- More than 12,000 commercial airline flights were grounded.
- The New York Stock Exchange closed for two consecutive days.
- The U.S. Army Corps of Engineers and others involved with FEMA recovery efforts reported they drained more than 470 million gallons of water from the New York City metro area, enough to fill all 843 acres of Central Park with roughly two feet of water.
- Damage estimates put the cost of the storm around $50 billion, the second costliest storm in the history of the United States.
- Two hospitals closed prior to the storm and three evacuated after the storm made landfall.

Because of the enormous impact of this type of storm—and the ever-growing concern about large-scale events happening more often in the United States—it is vital that the health care industry reflect on current emergency management practices and the vital role that health care plays in responding to disasters.

Emergency management is covered by the National Fire Protection Association's NFPA 99: *Health Care Facilities Code*. NFPA 99 is a wide-reaching code that is referenced by NFPA 101: *Life Safety Code*®, which is a requirement of certification through the Centers for Medicare & Medicaid Services (CMS). Therefore, compliance with both NFPA 101 and NFPA 99 are necessary for Medicare and Medicaid reimbursement.

ASHE would like to recognize the staffs of hospitals affected by Hurricane Sandy. Thanks to the tireless efforts and proper training of hospital staff members, no patients died or suffered serious injuries because of the massive storm.

Under NFPA 99, the key function of an emergency management program is to "assess, mitigate, prepare for, respond to, and recover from emergencies of any origin." Emergency management programs are primarily developed by a multidisciplinary committee that should consist of representatives from key areas within the health care organization, including senior management, physicians, nurses, infection preventionists, facility engineers, safety/industrial hygiene professionals, security staff, and other key individuals. The emergency management committee is responsible for the emergency operations plan, which is to be based on an incident command system in coordination with federal, state, and local emergency response agencies.

Much of Lower Manhattan was without power after Hurricane Sandy. But hospitals weathered the storm well and no hospital patients died or suffered serious injuries in the storm.

The importance of this coordination was truly highlighted in the successful efforts during Hurricane Sandy. Susan C. Waltman, executive vice president and general counsel of the Greater New York Hospital Association, emphasized this teamwork during the storm. "The fact that not one patient died or was seriously injured is a testament to the incredible work done by teams of dedicated people who communicate regularly throughout the year on how to prepare for a host of potential emergency situations," Waltman said. "Communication, cooperation, and collaboration are critical elements to the success of any emergency preparedness plan."

The emergency management program required by NFPA 99 must address four stages: mitigation, preparedness, response, and recovery. This is achieved primarily through a hazard vulnerability analysis, often called an HVA, and an emergency operations plan, often called an EOP. The hazard vulnerability analysis is used to identify and assess the potential risk of hazards that are most likely to impact a facility and the services provided. When performed properly, this analysis addresses the mitigation and preparedness phases of emergency management. The emergency operations plan documents the command structure to be used during an emergency and addresses the procedures for handling necessary critical functions, addressing the response and recovery phases of emergency management. Taking the time and effort to thoroughly analyze hazards and document operations plans prior to an emer-

gency is critical and was another key success factor to the responses during Sandy.

"Some of the encouraging things I've seen [in hospitals affected by Sandy] is that in some situations where a facility lost power, they didn't have to evacuate because they had plans in place for that event," said Chad Beebe, AIA, SASHE, ASHE deputy executive director for advocacy and a member of the committee that is responsible for NFPA 99. "I think that's a testament to their planning and care for their patients."

After the storm, ASHE conducted a survey regarding essential electrical systems and had responses from 390 health care facilities located within the area directly affected by Hurricane Sandy. The survey found that 138 facilities lost normal utility power, ranging from a loss of less than one hour (experienced by 10 percent of facilities) to an outage of 168 hours (experienced by 1 percent of facilities).

Of the 138 facilities that lost normal utility power, 13 reported that critical equipment did not transfer to emergency backup power within the 10-second period required by codes, and 24 others reported a problem with the backup power system before normal power was restored. Nine of these unanticipated outages were due to fuel system failures, while four were due to failures of cooling systems. Sixteen of the 24 unanticipated outages lasted for less than one hour, while four lasted longer than 96 hours.

Yet, despite these issues, not one of the 138 facilities surveyed required an evacuation due to loss of power. This shows the importance of detailed emergency management planning. Even when backup systems didn't work as expected, the hospitals successfully managed the situation and provided the needed care for their patients, remaining a viable resource to the communities they serve during a desperate time.

By adhering to the emergency management requirements of NFPA 99 and adequately analyzing and preparing for emergencies by taking steps such as regular practice drills, these medical services were available at a time when they were desperately needed. Lives were saved. The procedures worked, and the ASHE survey numbers help confirm that fact.

Hospitals may be taking the correct steps in planning, but many are going above and beyond code requirements. That's because the edition of NFPA 99 currently required by CMS is the 1999 edition, an outdated code. The 1999 edition—written before major events such as the 2001 terrorist attacks and Hurricane Katrina—contains significant differences from the 2012 edition.

For example, the 1999 edition requires that emergency planning be based on realistic conceptual events and operating capacity thresholds that necessitate activation of the plan—but no mention is made of a hazard vulnerability assessment or an emergency operations plan. These two documents are vital pieces of any emergency management program and are required by the 2012 edition.

CMS has proposed moving toward adoption of updated codes, and ASHE

applauds this shift. However, CMS has proposed its own emergency preparedness rules that differ from NPFA 99. ASHE has urged CMS to adopt NFPA 99 for emergency preparedness and will continue to keep members informed of actions on this CMS proposal.

Fortunately, health care organizations are already voluntarily accepting and applying the latest emergency management protocols even without a mandate to do so. Because of their efforts, hospitals are better prepared to provide vital services during difficult times when health care services are most needed and an untold number of lives can be saved.

A version of this article first appeared in the 2013 ASHE Advocacy Report.

The evolving hospital accreditation landscape

By Lynn Kenney
ASHE Senior Analyst for Advocacy

The Affordable Care Act (ACA) is driving change in nearly every area of health care and creating an increased focus on transparency, choice, quality, and cost savings. As health care continues to evolve, health care accreditation evolves as well. For more than 40 years there were two federally approved hospital accreditation programs. In the past few years, two additional accreditation programs have become available. Changes in health care along with policy changes in the Centers for Medicare & Medicaid Services (CMS) deeming authority[1] have likely contributed to this growth. Each accrediting organization offers a branded program aimed at helping hospitals navigate regulatory changes, improve quality, and distinguish themselves in an increasingly competitive market.

CMS deeming authority

Hospital accreditation programs with deeming authority have been evaluated by CMS and are deemed to be in compliance with the CMS Conditions of Participation (CoPs). This evaluation process is very involved and often takes years and significant investment to achieve. Once deemed status is achieved, the accrediting organization assumes oversight to determine compliance for participating hospitals, a process that includes a survey team conducting unannounced surveys that may occur annually or triennially depending on the accrediting organization.

While the accrediting organizations maintain oversight for participating hospitals, CMS maintains oversight for them. The accrediting organizations demonstrate ongoing compliance through validation surveys. CMS works with state survey agencies to evaluate a representative sample of facilities under review by each accrediting organization. These surveys include all the criteria in a standard facility accreditation plus a rigorous review of how the accrediting organization administers its program. Results are published in the *CMS Annual Report*, which is available online: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2013_CMS_Financial_Report.pdf.

Why hospitals seek accreditation

Medicare and Medicaid are major health care payers and are critical to the financial health of most U.S. hospitals. According to the American Hospital Association, Medicare and Medicaid ac-

[1] The enactment of MIPPA in 2008 removed Joint Commission's statutory status (effective 2010), giving CMS oversight of all national accrediting programs.

count for 58 percent of all hospital care and roughly 55 percent of annual revenues. To qualify for Medicare or Medicare reimbursement, hospitals must comply with the CMS Conditions of Participation (CoPs). Hospitals can demonstrate compliance via the federal survey and certification process offered through state survey agencies or they may choose to pay an approved accrediting organization.

Hospitals wishing to demonstrate their commitment to quality typically seek an accreditation partner. There are several reasons for this. First, each of the private accrediting organizations develops its own set of standards to help hospitals demonstrate they have voluntarily gone beyond minimum federal standards to demonstrate their commitment to a higher level of quality, health, and safety. Second, for the 1,400 teaching hospitals in the United States, accreditation is mandatory for practicing interns. Third, it helps the facility meet the necessary criteria for Medicare and Medicaid reimbursement.

Even hospital systems that do not participate in the Medicare and Medicaid reimbursement programs—such as Indian Health Services, Veterans Administration, Department of Defense, and international facilities—seek private accreditation to demonstrate their commitment to health, safety, and quality.

Accreditation options

The Joint Commission (JC) and Healthcare Facilities Accreditation Program (HFAP) have had deeming authority from CMS since 1965. In 2008 CMS granted deeming authority to Europe-based Det Norske Veritas (DNV GL). In 2013 deeming authority was granted to a fourth organization, the Center for Improvement in Healthcare Quality (CIHQ). And while there are currently four hospital programs with deeming authority, CMS grants deeming authority to a total of eight accrediting organizations. Each one specializes in a specific area of health care and some offer programs for more than one area, including hospitals, critical access hospitals, home health agencies, hospice facilities, ambulatory surgical centers, psychiatric hospitals, outpatient physical therapy facilities, and rural health clinics. Partnering with an accrediting organization with several programs will help hospital systems offering these other services.

Accrediting organization standards/ CMS standards/state licensure requirements

ASHE's goal is to advocate for consistency in code interpretation and application to reduce regulatory confusion and ensure that resources are spent on patient care rather than dealing with conflicting code requirements. But the current adoption and enforcement model creates confusion for hospitals and enforcers. For example, CMS currently adopts the 2000 edition of NFPA 101: *Life Safety Code*® and has written these fire and life safety standards into the CoP regulations. Hospitals must also comply with state licensure requirements, which vary by state and may include requirements from differ-

ent editions of the *Life Safety Code* along with varying editions of building codes. As a result, state and local codes often differ from federal requirements.

In addition, every accrediting organization has its own set of standards and its own team of surveyors, which may add complexity for state surveyors and other authorities having jurisdiction who need to keep pace with regulatory changes to understand and work across different standards.

Will the accrediting landscape continue to change?

As models of care change and evolve, existing programs will likely continue to evolve and additional programs may emerge. For example, most accrediting organizations now offer disease-specific care certification. And the increase in outpatient and ambulatory procedures in small hospitals factored into an expansion announcement earlier this year by the Accreditation Association for Ambulatory Healthcare (AAAHC). The new program, the Accreditation Association for Hospitals/Health Systems (AAHHS), focuses on rural hospitals, critical access hospitals, and small hospitals with fewer than 200 beds. AAHHS states the new program is in the CMS approval process for hospital deeming authority. Expansion is also likely to continue internationally as U.S. hospital systems expand globally. Currently Joint Commission International (JCI) and DNV offer international accreditation programs.

For more information, visit:

www.jointcommission.org

www.hfap.org

www.dnvglhealthcare.com

www.cihq.org

www.aahhs.org

	The Joint Commission (JC)	Healthcare Facilities Accreditation Program (HFAP)	Det Norske Veritas (DNV GL) National Integrated Accreditation for Healthcare Organizations (NIAHO)	Center for Improvement in Healthcare Quality (CIHQ)
Approximate Number of Accredited Hospitals	4,400	210	375	4
Accreditation Requirements	Standards based on CMS CoPs. ISO 9001 is optional: • Environment of Care • Emergency Management • Human Resources • Infection Prevention and Control • Information Management • Leadership • Life Safety • Medication Management • Medical Staff • National Patient Safety Goals • Nursing • Performance Improvement • Provision of Care, Treatment, and Services • Record of Care, Treatment, and Services • Rights and Responsibilities of the Individual • Transplant Safety • Waived Testing	Standards based on CMS Health and Safety Standards and National Quality Standards: • Quality Assessment and Performance improvement program • Medical Staff • Nursing Services • Medical Record Services • Nursing Services • Pharmaceutical Services • Radiologic Services • Food and Dietetic Service • Laboratory Services • Utilization Review • Physical Environment (including Emergency Preparedness) • Infection Control • Discharge Planning • Organ, Tissue, and Eye Procurement • National Patient Safety Initiatives	Standards based on CMS CoPs and ISO 9001: • Physical Environment (PE) (Covers concepts derived from ISO compliance): PE.1-Facility, PE.2-Life Safety Management System, PE.3-Safety Management System, PE.4-Security Management System, PE.5-Hazardous Materials Management System, PE.6-Emergency Management System, PE.7-Medical Equipment Management System, PE.8-Utility Management System • Quality Management System • Governing Body, Chief Executive Officer • Medical Staff, Nursing Services, and Staffing Management • Rehabilitation Services, OB Services, Dietary Services, and Respiratory Care Services • Outpatient Services, Emergency Department • Patient Rights, Medical Records Service • Infection Control • Medication Management • Surgical Services, Anesthesia Services, and Laboratory Services • Medical Imaging • Nuclear Medicine Services • Discharge Planning, Utilization Review • Organ, Eye, and Tissue Procurement	Standards are based on CMS CoPs as well as additional standards to address patient safety and quality concerns: • Governance & Leadership • Quality Assessment & Performance Improvement • Medical Staff • Human Resources • Managing the Care Environment • Infection Prevention & Control • Emergency Preparedness • Ulilization Review • Patient Rights • Medication Management • Management of Medical Record • Use of Restraint & Seclusion • Targeted Patient Quality & Safety Practices • Anesthesia Services • Dietary Services • Discharge Planning Services • Emergency Services • Laboratory Services • Organ, Tissue, & Eye Procurement • Nuclear Medicine Services • Nursing Services • Operative & Invasive Services • Outpatient Services • Radiology Services • Rehabilitation Services • Respiratory Services • Pyschiatric Hospitals

	The Joint Commission (JC)	Healthcare Facilities Accreditation Program (HFAP)	Det Norske Veritas (DNV GL) National Integrated Accreditation for Healthcare Organizations (NIAHO)	Center for Improvement in Healthcare Quality (CIHQ)
Survey Process	Unannounced on-site surveys are conducted by the Joint Commission survey team using tracer methodology and quality improvement measures. The Statement of Conditions (SOC) is created and maintained by the facility to assess the physical environment, identify deficiencies, and create a plan for improvement. Facilities demonstrate continuous compliance by proactively identifying deficiencies in the Plan for Improvement (PFI). Surveyors spot-check the SOC to verify accuracy along with a timetable for correction. Deficiencies must be resolved within a given timeframe.	Unannounced on-site surveys are conducted by an HFAP survey team using the CORE (Care Observations Review and Evaluation) survey methodology that incorporates tracers, direct care observations, and review of facility documents (facility maintenance plans, minutes, medical records, etc.). A Deficiency Assessment Report is provided within ten days of survey completion. Facilities submit a Plan of Correction (PoC) and/or evidence of compliance within ten calendar days of receipt of the deficiency report.	Unannounced on-site surveys are conducted by DNV survey teams using tracer methodology. The DNV physical environment surveyors are, in many cases, the DNV Survey Team Leader. Review includes observation of care and services provided to the patient in all patient care areas, including both inpatient and outpatient, as well as family interviews, staff interviews, and medical records review. DNV surveys all non-clinical and off-campus areas. Nonconformities (NC) are identified and the Corrective Action Plans (CAP) are identified based on the level of severity: • NC-1: Facility has 30-45 days to correct finding with resurvey after 45 days. • NC-2: This is for a more involved issue (e.g., doors). Facility is asked to submit a plan of correction within 30-45 days and resolve within 1 year.	Unannounced surveys conducted by CIHQ survey team including a dedicated facilities specialist to assess compliance with the *Life Safety Code®*.
Survey Frequency	Triennial, with an annual self-assessment (periodic performance is prepared by the hospital)	Triennial	DNV surveys the entire campus, including off campus sites, over a three-year period. Some issues and areas that are surveyed every year. DNV attempts to complete the full survey in year one, with subsequent annual surveys to follow up on Corrective Action Plans (CAP).	Triennial with a one-day mid-cycle survey

	The Joint Commission (JC)	Healthcare Facilities Accreditation Program (HFAP)	Det Norske Veritas (DNV GL) National Integrated Accreditation for Healthcare Organizations (NIAHO)	Center for Improvement in Healthcare Quality (CIHQ)
Surveyors	Dedicated life safety surveyors stay for three to four days depending on the size of the facility. Surveyors have health care experience, must pass a certification exam, and must receive ongoing training from the Joint Commission.	Surveyors are typically hospital facility managers and training is provided by HFAP. In spring 2014, HFAP added a life safety surveyor to the survey team for one to two days depending on the size of the facility.	Surveyors must complete National Integrated Accreditation for Healthcare Organizations (NIAHO) surveyor training and ISO 9001 Lead Auditor training. Physical Environment (PE) specialists typically have a facility/safety background. Ongoing education and training is required.	Dedicated facilities specialists
Accreditation Levels	Accredited, Provisional, Conditional, Preliminary Denial	Preliminary Accreditation, Accreditation, Accreditation with Follow-up, Denial of Accreditation	Accredited Denial of Accreditation	Standard Level Deficiency, Condition Level Deficiency, Immediate Threat to Health & Safety Deficiency (deficiencies can be corrected during survey if certain conditions are met)
Barrier Penetration Program	yes	not required	yes	no
Survey Off-Site Diagnostic and Other Buildings	yes	not required	yes	CIHQ will survey all departments, services, and locations that bill for services under the hospital's provider number and are considered part of the hospital.
Accreditation Support	Accreditation support is offered via dedicated account representatives, standards interpretation, patient safety alerts, electronic tools, and webinars. Accreditation manuals and reference publications are available through Joint Commission Resources.	Accreditation fee includes HFAP manuals, webinars, standards interpretation, and CMS Conditions of Participation (CoPs) cross references.	National Integrated Accreditation for Healthcare Organizations (NIAHO) manuals are available to accredited facilities along with webinars and standards interpretation.	Accreditation fee includes CIHQ accreditation standards along with support, education and standards interpretation
Website	www.jointcommission.org	www.hfap.org	www.dnvaccreditation.com	www.CIHQ.org

Managing barriers and avoiding Joint Commission citations

By Jonathan Flannery, CHFM, FASHE, MHSA
ASHE Senior Associate Director of Advocacy

In recent years, seven of the top 10 hospital citations from the Joint Commission have stemmed from problems in the health care physical environment. Most alarming in this list of common citations is the perennial inclusion of several standards related to fire and smoke barrier systems, indicating a long-term issue with these systems. To address this issue, the Joint Commission, Firestop Contractors International Association (FCIA), American Society for Healthcare Engineering (ASHE), and Underwriters Laboratories (UL) came together to develop a comprehensive and informative new symposium that focuses on proper design, installation, inspection, and maintenance (DIIM) of fire and smoke barriers and associated features, including firestopping, fire dampers, fire-rated glazing, and fire doors that make compartmentation effective in health care facilities.

In 2013 the Joint Commission's third most cited compliance issue was for Life Safety Standard LS.02.01.10 – "Building and fire protection features are designed and maintained to minimize the effects of fire, smoke and heat." Citations in this area are directly related to fire barrier penetrations, fire door issues, and duct issues. "Almost half the time we surveyed, we found problems with our barriers," said George Mills, MBA, FASHE, CEM, CHFM, director of the Department of Engineering at the Joint Commission. Although penetrations within fire barriers are the leading citation issue, the failure of fire doors is another significant problem. Hospital doors experience a lot of wear and tear in daily operations, which can lead to damaged door hardware and doors that do not close properly.

Number six on the Joint Commission's list of 2013 compliance issues was Environment of Care Standard EC.02.03.05 – "The hospital maintains fire safety equipment and fire safety building features." Citations in this area are related to the maintenance, testing, and inspection of fire protection features. Many times the testing has been done properly, but poor documentation or improper follow-up on the documentation leads to citations. The failure to completely understand the documentation provided by third party testing organizations or to have timely access to the documentation has led to citations. Lack of a proper written inventory of the components of fire protection systems has also led to citations under this standard, along with the failure to prop-

Smoke and fire barrier penetrations are a top cause of Joint Commission citations in hospitals.

erly correct deficiencies indicated on the documentation in a timely manner.

Coming in at number seven on the 2013 citation list was Life Safety Standard LS.02.01.30 – "The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke." The chief issue leading to these citations is penetrations in smoke barriers. The failure to properly fill these penetrations with appropriate fire-stopping material is the leading cause for citations under this standard.

One of the primary reasons ASHE joined with other groups to create the Barrier Management Symposium was the fact that these citations have been a problem for years. Over the past five years, these three standards have not only been in the top 10 compliance issues, but LS.02.01.10 has been one of the top two most cited compliance issues each year. While standard LS.02.01.30 has seen some improvement over the last two years (dropping to number six and seven, respectively) the three years prior to this it was consistently the fifth most cited standard. Standard EC.02.03.05 has also seen some improvement (dropping to number six in 2013) but was as high as the second most cited standard in previous years and did not make it out of the top five until 2013. This clearly indicated a need to increase awareness of how to better design, install, inspect, and maintain fire and smoke barriers for long-term success while providing increased safety for patients, staff, and visitors.

The Barrier Management Symposium focuses on the proper DIIM of fire and smoke barriers and the system components that make effective compartmentation within health care facilities. Hospitals do not typically evacuate patients during most emergencies. Instead, hospitals are designed with special features, including compartmentation and smoke and fire protection, to accommodate defend-in-place methods that keep patients protected within safe zones in the hospital. This prevents the unnecessary movement of patients, many of whom rely on life-sustaining equipment or who would be harmed by a sudden evacuation.

Since hospitals are so reliant upon the defend-in-place strategy when it comes to fire response, it is vital that the compartmentation of the hospital function properly. Relying on this type of a strategy requires that the building provide additional protection for those who cannot readily evacuate during an emergency. One of the symposium's goals is teaching that the barriers are more than just walls—they are a system crucial to successfully protecting our

patients and staff, Mills said. For the defend-in-place model to be successful in health care, the physical barriers, suppression and fire response, and notification and alarms must all be reliable, Mills added.

The defend-in-place strategy also requires additional staff responsibilities. In addition to proper training and regular drills to make sure all staff know how to properly respond as part of the defend-in-place strategy in the event of an emergency, facility staff at health care institutions are required to carry out regular inspections of their passive fire protection systems and to properly maintain them. This includes firewalls, fire doors, fire dampers, and smoke dampers. "A consistent training program that teaches the theory behind the design and then how to maintain and evaluate should increase compliance, and result in a safer health care environment," Mills said.

The Barrier Management Symposium provides in-depth education to help staff understand the various aspects of smoke and fire systems, including the testing that qualifies products for use, code requirements, installation, inspection, and the management and maintenance of barriers for ongoing reliability. "The [program] also emphasizes the fact that these products become systems when they are properly 'DIIM'd," said Bill McHugh, executive director of FCIA. The symposium includes video presentations and an explanation of how each design element is tested to assess compliance with code requirements.

One of the key goals of the symposium is making the education accessible to as many health care facility professionals as possible. Mills stressed the importance of consistent education programs across localities and regions. To accomplish this goal, the Joint Commission, FCIA, ASHE, and UL are delivering the program in locations around the nation.

ASHE is partnering with the affiliated chapters in each of the 10 ASHE regions to coordinate and host the symposium on a local basis. The one-and-a-half-day symposium is centrally located in the region and scheduled to help reduce travel as much as possible. To help keep the costs of the program to a minimum , all program faculty donate their time and travel expenses. To date, symposiums have been delivered within Regions 2, 4, and 8 with more being scheduled for later this year in Regions 5 and 9. To find a symposium near you, please visit www.fcia.org/barriermanagementsymposium.htm.

The symposium encourages facility professionals to:

Focus on technologies that have protected buildings for centuries.

Improve the health care built environment, which demands the best in fire and life safety, through effective compartmentation.

Manage the product and system evaluation, installation, inspection, and maintenance of fire and smoke barrier components as a complete system. These systems are integrated to work together to provide reliable building safety.

Increase knowledge about how to purchase, evaluate, and manage all effective compartmentation technologies.

Is your facility compliant with these commonly cited Joint Commission standards?

Life Safety Standard LS.02.01.10 – Building and fire protection features are designed and maintained to minimize the effects of fire, smoke and heat.

Environment of Care Standard EC.02.03.05 – The hospital maintains fire safety equipment and fire safety building features.

Life Safety Standard LS.02.01.30 – The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

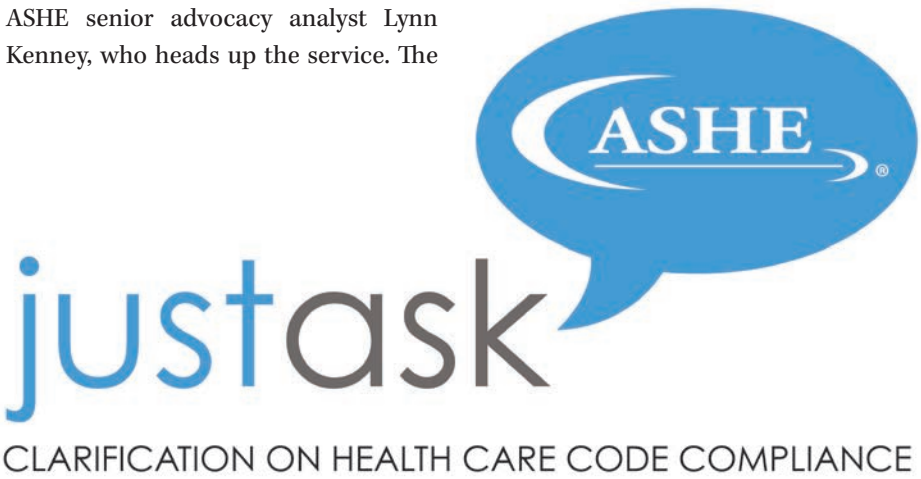
Code questions? Just Ask ASHE

By Deanna Martin
ASHE Communications Manager

Those responsible for health care facility compliance understand that the many codes and standards regulating hospitals aren't always clear-cut. Code questions can arise from unclear code language, unaddressed issues in codes, conflicting code requirements, or conflicting interpretations from authorities having jurisdiction (AHJs).

The Just Ask ASHE service helps ASHE members get reliable answers from code experts. This free service, available only to ASHE members, offers answers to a wide range of questions. Recently, members asked whether hospitals can use "household" appliances and whether a decorative hanging quilt can meet code requirements (keep reading to find the answers).

ASHE has a team of more than 30 experts to answer such questions, said ASHE senior advocacy analyst Lynn Kenney, who heads up the service. The people answering questions are involved in committees, task forces, and advisory groups for a wide variety of code-making organizations, including the National Fire Protection Association; the International Code Council; the Joint Commission; DNV Healthcare; the Facility Guidelines Institute; the American Society of Heating, Refrigerating and Air-Conditioning Engineers; the Centers for Disease Control and Prevention; and the Occupational Safety and Health Administration, among others. Because of this, the Just Ask ASHE team is uniquely positioned to provide information that considers the many viewpoints, codes, and regulations that make up health care compliance.



"Just Ask ASHE pulls all the experts together so that our members have a single source for reliable answers," Kenney said.

ASHE members can ask questions using the Just Ask ASHE website (www.ashe.org/JustAskASHE), where a legal disclaimer is found. Or look for the folks wearing the Just Ask ASHE team member badge at the ASHE Annual Conference to ask a question. They'll be happy to help.

Q: Many devices have UL warnings stating "household use only," but are there regulations prohibiting their use in hospital settings?

A: There is no formal code that disallows "household use only" items from being used in a hospital, although these items should be used as intended by the manufacturer and their use may not be appropriate for every condition, situation, or space. To determine whether these items would be appropriate, the facility should have a policy and risk assessment procedure to manage the use of such equipment in the facility. Surveyors would then verify that the policy and associated risk assessment are being adhered to by the facility. Without a policy and risk assessment procedure provided by the facility, the surveyor would have to make a personal determination on whether these types of items are being used appropriately.

Q: A Massachusetts hospital's community relations department wants to hang a quilt in an exit access corridor and suggests using a spray-on product to meet NFPA 701 specifications. Is this an acceptable solution?

A: A textile wall hanging is considered a decoration under the *Life Safety Code*. The 2000 edition of the code states that loosely hanging textiles must meet the 1999 edition of NFPA 701: *Standard Methods of Fire Tests for Flame Propagation of Textiles and Films*. If the spray-on material allows the quilt to meet Test 1 of NFPA 701, it would be allowed under the *Life Safety Code*. However, it is unclear how conformance to the test could be confirmed short of having the test performed. In addition, there are some additional state-specific considerations. Approval from the local fire department would be required, and samples would be needed for testing, according to Massachusetts codes. The state limits decorative material to no more than 10 percent of the wall area to which it is attached. One possible solution would be encasing the quilt in a glass case that does not extend into the hallway or impede egress.

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We want you—to get involved in advocacy efforts

By Chad Beebe, AIA, SASHE
ASHE Deputy Executive Director of Advocacy

ASHE advocates in many different arenas in many different ways. ASHE's advocacy team, made up of five employees, has a goal of using collaboration and communication to advocate on behalf of hospitals and patients to help ensure the delivery of world class care is affordable and responsive to patient needs. By ensuring that hospitals do not unnecessarily spend resources on conflicting or outdated codes, we can further support the missions of hospitals to provide patient care.

Over the past year, ASHE has proposed hundreds of code changes to help in the quest for unified codes. Many of the changes aligned provisions to create consistency between various regulations. We asked committees to reevaluate older provisions that were no longer needed or redundant. And we suggested changes to avoid potential future conflicts by removing sections and referencing other resources. The ASHE advocacy team spends more than 5,000 man-hours each year trying to accomplish and maintain the goal of unified codes. Still, it is difficult for the advocacy team to go it alone.

A number of ASHE members have come forward and volunteered their time to help on various committees. To get the voice of health care facility professionals heard by everyone in the standards-making universe, we estimate we would need about 100 active members to volunteer with this effort. To date, we have about 30 actively engaged members in code development. ASHE encourages everyone to get involved with these efforts, which can save valuable health care resources during a time of financial and regulatory challenges.

ASHE also works with local ASHE-affiliated chapters to solicit volunteers and discuss codes and standards issues. ASHE's advocacy team calls its relationship with chapter advocacy liaisons the Advocacy Highway because it is a two-way street of communication about codes and standards issues affecting hospitals locally and nationwide.

Changing the rules in your state

"I'm just a bill, yes I'm only a bill, and I am sitting here on Capitol Hill…" You probably remember the Schoolhouse Rock! tune "How a Bill Becomes a Law," but if not you can search for it on YouTube and enjoy a bit of Saturday morning nostalgia. This mid-70s video short may be what you think about when it comes to getting a rule changed in your state. In most cases, the process of changing rules is even easier than the legislative process described by the cartoon bill in the video. With the exception of Arizona, California, Texas, New Jersey and a few others, state administrative branches generally license hospitals by rules developed under the authority given to them by the legislature.

The process for changing administrative rules is almost as simple as reaching out to the agency responsible and explaining the need to do so. Whether you are looking to get the state to adopt the latest edition of a Facility Guidelines Institute *Guidelines* document, update to the new building codes, or extend the rainbow trout fishing season, it may be as easy as asking them to consider the change. Of course, the more compelling the reasons and the better the data you bring when making your case, the better your chances for success.

Should your state have a law that you need to change, reach out to your local legislator. People often forget how accessible their representatives can be. If you can narrow your issue to a two-minute elevator speech, you may just find someone who is willing to take the issue on and carry it from there.

Changing codes and standards

When I was an authority having jurisdiction in Washington state, I used to hear a lot of complaints about the National Fire Protection Association and other code development organizations from customers asking, "What were they thinking when they wrote this?" The fact is that code development organizations don't write any of their codes or standards. You do.

The standards development organizations are there to administer and support the process. Often they act as publisher of the final documents as well. But the content of code documents depends on the users of the documents and the proposed changes they submit.

Proposing changes is easier than it may sound. I submitted 15 proposals on one document the other day. It took me about two hours, with interruptions. The fact is that it doesn't take all that much time to suggest a change, and it's far better to propose a change to a document than to live with a provision I can't see the value in. Often when I submit changes I receive a response from the technical committee either accepting the proposal or providing me with additional information I did not initially consider. Regardless, the committees are also made up of people like you and me with an interest in the particular topic area. Some of the changes are addressed by committee members from their experiences in the field, but the committee doesn't really have a stake in changing the codes for the sake of changing the codes. The committee's time is spent re-

viewing the hundreds of proposals made every cycle. The ones that typically make it into the codes are the ones that have reasonable justification.

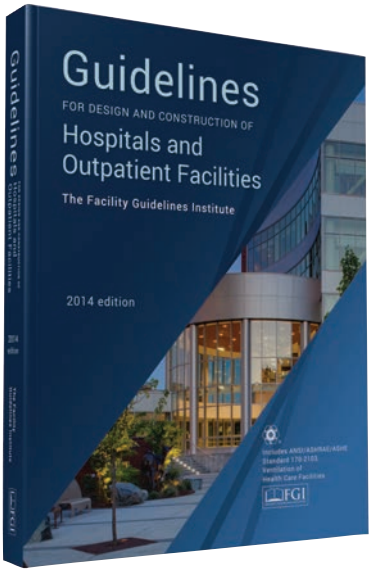
So the next time you find yourself scratching your head and wondering "why is this in the code?," get involved. Go to the standard making organization's website and download the proposal form, or submit the proposal online. It's easy, but if you have any questions feel free to contact the ASHE advocacy team for more information. You can reach us at advocacyhighway@aha.org.

Government owned and operated hospitals have voting privileges at International Code Council (ICC) hearings. Currently, very few public hospitals are involved in the ICC rule development process. To obtain voting privileges, the hospital needs to become a member of the International Code Council and get involved. If you qualify for this role, we need to hear from you! Contact us at advocacyhighway@aha.org.

Enacting change in your state is often easier than you expect because changes can often be made by state administrative agencies rather than legislative bodies.

Getting the latest edition of the FGI *Guidelines* adopted in your state

By Chad Beebe, AIA, SASHE
ASHE Deputy Executive Director of Advocacy



The Facility Guidelines Institute (FGI) updates the *Guidelines for Design and Construction of Hospitals and Outpatient Facilities* every four years, creating a document used by states and federal agencies to regulate health care facility design and construction. However, some states have not yet adopted the *Guidelines* and others require compliance with old editions of the document. This patchwork of varied, outdated applications of the *Guidelines* can siphon hospital resources that could otherwise go toward patient care.

The provisions of the FGI *Guidelines* are based on research and determined to be the industry minimum standard. These minimum standards are supported by the American Hospital Association, the Department of Health and Human Services, the Joint Commission and other national organizations.

As states create or adopt different standards, it adds to regulatory complexity—especially for health care systems with facilities in several states. In addition, design teams that work in multiple states are challenged with conforming to the many different standards. Using a uniform standard across the nation would help those involved in the design, construction, and operation of health care facilities create hospitals that are more efficient to build and to operate and support improved patient outcomes.

The process for changing regulations may sound complex and time-consuming, but it is really not that difficult to affect change in your state. Changes in laws and rules happen all the time. Often, state legislators or state agencies initiate bills to change the status quo after being approached by a constituent or stakeholder who communicates the importance of the proposal. State agencies are often happy to make changes initiated by their stakeholders.

But lawmakers don't shift policy unless there is a reason—if they have not been asked to do so or no one has identified an issue as a priority, it is unlikely that change will occur. We hope the tools included in this Advocacy Report and this article will help ASHE members communicate the importance of unified codes to state agencies.

FGI, ASHE, ASHE chapters, state hospital associations, and local AIA chapters are advocating for the adoption of more recent editions of the *Guidelines*. It is imperative that individuals also champion these proposals at the state level.

The process of enacting change starts by developing your position and connecting with the appropriate state agency. We suggest the following steps:

- Identify the rule that needs to be changed.
- Draft a proposed rule that shows the change. It is a good idea to have something for the agency or other stakeholders to consider.
- Compare the existing rule to the proposed change to show the pros and cons of making the switch.
- Identify potential fiscal effects of adopting the *Guidelines*.
- Develop a coalition of interested stakeholders. One of the major concerns for any state agency is negative input from stakeholders about a proposed rule. Working with a contentious rule often draws out the rule-making process and becomes very expensive for the agency, which is often what keeps state agencies from embarking on a major rule revision. Therefore, the more stakeholders you can gather to support a proposed rule, the better. It will help reassure the state agency that adoption is not a contentious issue.
- Contact the state agency and set up a face-to-face meeting to discuss your proposal.

Once a state agency has agreed to move forward on a proposed rule, then the process is dictated by the agency.

ASHE has a number of tools to help with the adoption effort, including side-by-side comparisons, burden estimates, sample draft letters, and proposed rule drafts. For additional information and to get started advocating for your state to adopt the most current edition of the *Guidelines*, contact the ASHE advocacy team at advocacyhighway@aha.org.

ASHE is often asked where someone new to health care design and construction can get a full overview of the FGI *Guidelines*. Unlike the typical updates found during various conferences, many of our members are looking for a full education on how to understand and interpret the entire document. Over the course of the next several years, ASHE will be preparing an e-learning product for that purpose. Subscribers to this service will be able to review the many different sections of the *Guidelines*, learning more about the specific requirements for areas of hospitals when they become pertinent to a project they are designing, managing, or constructing. In addition to this new, flexible format, webinars will be scheduled to provide in-depth review of specific *Guidelines* sections. These will also be made available to subscribers of the e-learning system.

Raise your voice: Make the most of your public comments

By Chad Beebe, AIA, SASHE
ASHE Deputy Executive Director of Advocacy

ASHE's advocacy team works diligently to inform members of potential code changes but cannot shift policy on its own. So ASHE often asks members like you to submit public comments on regulatory issues. Code-writing organizations seek input as they create regulations, and organizations such as the Centers for Medicare & Medicaid Services (CMS) seek public comments before adopting codes and making rules.

Submitting public comments can be an effective way to raise issues and suggest changes. By understanding the best ways to submit comments, ASHE members can ensure their voices are clearly heard. While the opportunity for comment is not a vote, comments do matter. Many unique, individual comments can make a change.

Public comments don't have to be elaborate, they just need to communicate your thoughts. The more tangible data you can provide, the better. For example, if you are refuting the cost of installing a smoke exhaust system and have recently installed such a system, you can provide a redacted copy of the project bid.

It is important that ASHE members do not directly copy each other's comments, however. The comments need to be original to be heard. Many people mistakenly believe their submitted form letter constitutes a "vote" regarding the issues concerning them. Although public comments may help guide policies, agencies make determinations for a proposed action based on sound reasoning and scientific evidence, not a majority of votes. A single, well-supported comment may carry more weight than a thousand form letters.

Here are some additional tips for submitting public comments:

1. Clearly identify the issues in the regulatory action on which you are commenting. If you are commenting on a particular word, phrase or sentence, provide the page number, column, and paragraph citation from the *Federal Register* document.

2. If a rule raises many issues, do not feel obligated to comment on every one — select those issues that concern you the most, affect you the most, and/or you understand the best. Be concise.

3. Although agencies receive and appreciate all comments, constructive comments (either positive or negative) are the most likely to have an influence.

4. If you disagree with a proposed action, suggest an alternative (including not regulating at all) and include an explanation and/or analysis of how the alternative might meet the same objective or be more effective.

5. The comment process is not a vote. The government is attempting to formulate the best policy, so when crafting a comment it is important that you adequately explain the reasoning behind your position.

6. Identify credentials and experience that may distinguish your comments from others. If you are commenting in an area in which you have relevant personal or professional experience (i.e., facility manager, architect, etc.) say so.

7. Agency reviewers look for sound science and reasoning in the comments they receive. When possible, support your comment with substantive data, facts, and/or expert opinions. You may also provide personal experience in your comment, as appropriate. By supporting your arguments well, you are more likely to influence the agency 's decision-making.

8. Consider including examples of how the proposed rule would impact you negatively or positively.

9. Comments on the economic effects of rules that include quantitative and qualitative data are especially helpful.

10. Include the pros and cons and trade-offs of your position and explain them. Consider other points of view, and respond to them with facts and sound reasoning.

By keeping these tips in mind, you can make sure your comments carry as much weight as possible. ASHE members should watch the *ASHE Insider* newsletter for opportunities to comment on proposed changes to codes and standards.

ASHE needs your help

The goal of creating streamlined, science-based codes and standards is a major undertaking that requires support from people in a wide variety of professional positions.

Lawmakers: ASHE urges lawmakers to support local and national efforts to streamline codes and standards while protecting patients. Lawmakers at every level can check with local hospitals to see if a facility manager there is an ASHE member, and can encourage hospital leaders to support ASHE advocacy efforts. State lawmakers can urge their legislatures to adopt the most recent edition of the FGI *Guidelines* as soon as new editions are released. Senators and Congresspersons can urge the Centers for Medicare & Medicaid Services to adopt the most recent edition of the *Life Safety Code*. For more ideas on how lawmakers can get involved and help direct more hospital resources to patients, contact ASHE.

Health care administrators: ASHE encourages health care administrators to ensure that their facility managers, as well as others in related positions, are members of ASHE and are actively engaging in ASHE's codes and standards efforts. ASHE is always looking for active volunteers to help promote better codes and standards, and it is important for health care administrators to support these undertakings. Administrators can also reach out to local building officials to discuss code issues and explain the ways hospitals protect their patients. To learn more about the advantages of ASHE membership for hospital employees, contact ASHE.

Code development organizations: ASHE urges code development organizations to develop and maintain procedures to ensure codes are minimum requirements based on science. ASHE is a resource for learning how various proposed changes would affect the health care environment. To learn more about this issue, contact ASHE.

Health care accrediting organizations: ASHE is a helpful resource for accrediting organizations that survey health care facilities to ensure compliance with codes. ASHE wants to work with these organizations to help optimize the health care physical environment. To learn more about this topic, contact ASHE.

State and local building officials: ASHE encourages code officials and those involved in the code development process to learn more about hospitals and the regulations affecting them. Many building officials and other authorities involved in the code development process do not have hospitals in their jurisdictions and may not fully understand the regulatory measures in place to ensure safe operation and maintenance of health care facilities. ASHE encourages code officials to talk to local ASHE members about the safety measures hospitals take. Officials can contact ASHE using the contact information on the back of this report.

ASHE members: ASHE members can turn to the weekly electronic newsletter included as part of ASHE membership, the *ASHE Insider*, for information about upcoming ways to get involved with advocacy efforts, including public comment periods on various codes. ASHE members can talk to their local chapter's advocacy liaison for more information, or contact ASHE.

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