

# ASHE 2015 Advocacy Report

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

**Working to reduce conflicts  
and regulatory confusion**

**Resources to keep your  
hospital in compliance**

**How you can help improve  
codes and standards  
regulating hospitals**

Photo Credit: Halkin Mason Photography  
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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](http://www.ashe.org).

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# Letter to Readers

Our ASHE advocacy staff spends most of their time on the road, traveling around the country working to develop, update, improve, and explain the codes and standards that regulate hospitals and other health care facilities. Our goal is to create unified codes—codes that are based on science and data, codes that do not conflict with other regulations, and codes that are up to date.

Some of our recent efforts are included in this edition of the *Advocacy Report*, including our work on relocatable power strips, barrier management, and ASHRAE 188P. Understanding these issues is critical for health care facility professionals and others who need to know the latest regulations affecting hospitals.

This publication also includes information on the importance of getting involved, and suggests ways that you can get involved to help improve health care regulation. ASHE helps lead the effort toward better codes and standards, but it's your voice that influences the changes.

**We aren't asking you to quit your day job and devote your life to advocacy. You don't need to attend every code development technical subcommittee or pore over the Federal Register looking for proposed agency rules. But as an ASHE member, it's important that you understand the significance of getting involved in these efforts.**

Your voice can help us create better codes and standards for health care facilities. Important codes and standards decisions often come down to a few votes. Attending a meeting like the NFPA hearing in 2017 (see the article on page 16) can make a real difference. Acting locally can help improve regulations in your state (see the article on Washington State on page 13). At other times, simply writing a letter can affect change (see the article on WMTS on page 10). Taking just a few minutes out of your busy day can result in code changes that benefit your hospital for years to come.

We cannot undertake the monumental task of creating unified codes without your help. We understand you are dealing with competing priorities, limited time, and budget constraints. We also know that as an ASHE member, you are dedicated to optimizing the health care physical environment. Part of that mission is optimizing the codes and standards that regulate our facilities, and **we can't do it without you**. Please turn to the last page of this publication to see how you can get involved, or contact me for more information.



Sincerely,

A handwritten signature in blue ink, appearing to read 'Chad Beebe', with a stylized flourish at the end.

Chad Beebe, AIA, SASHE  
ASHE Deputy Executive Director of Advocacy  
cbeebe@aha.org

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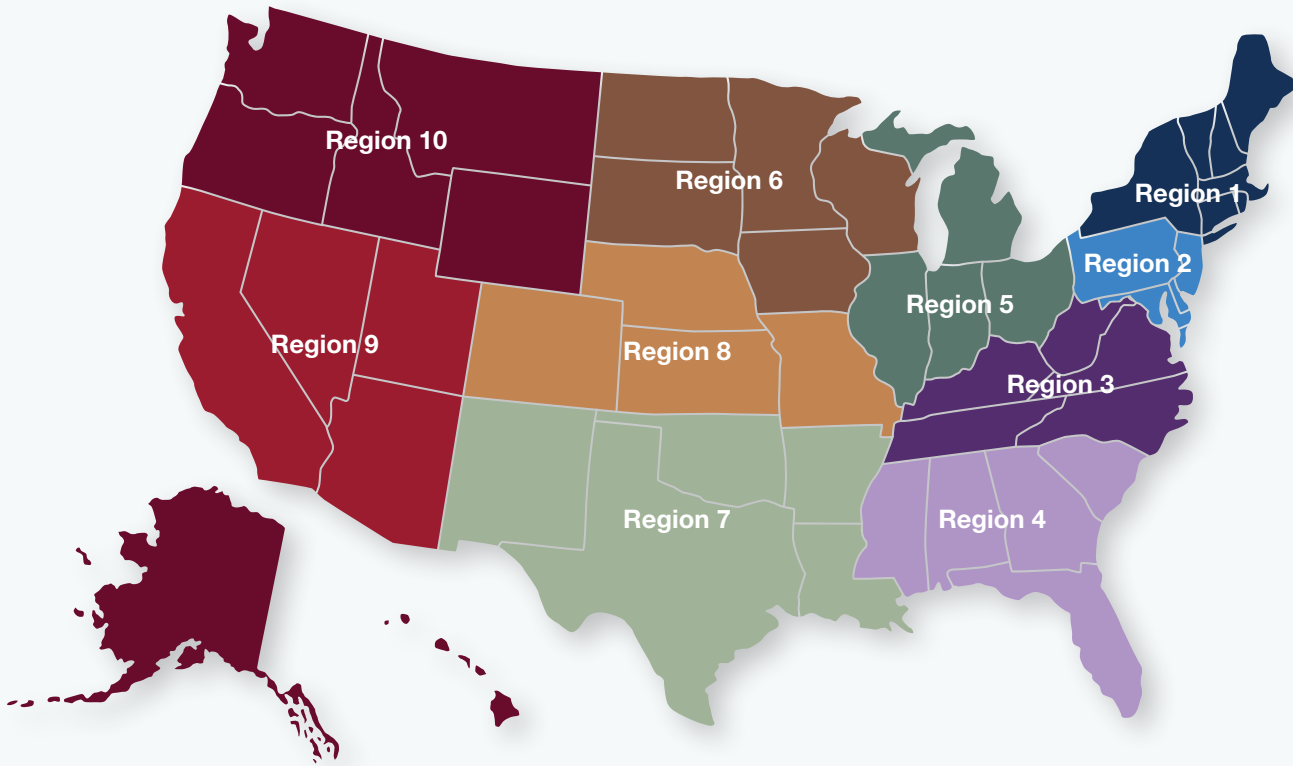
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ASHE uses a committee structure of volunteers to help carry out directives from the Board of Directors. ASHE committees work on advocacy, education, chapter relations, and membership issues. ASHE’s Advocacy Advisory Committee includes experts who work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

**Chair Tom Stewart, MBA, SASHE,  
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MSL Healthcare Partners  
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# Advocacy team creates compliance tools and resources

By **Deanna Martin** ASHE Communications Manager

In addition to working on improvements to the codes and standards that regulate health care facilities, the ASHE advocacy team creates useful compliance tools and resources for ASHE members. The team has recently created several new member tools, including:

**CMS waiver tools:** ASHE has compiled a comprehensive list of all the categorical waivers currently offered by the Centers for Medicare & Medicaid Services (CMS). A sample waiver template is also available for ASHE members to download and edit for use in your facility.

**RPT tools and guidance:** CMS is offering waivers that allow power strip use in patient care areas in certain circumstances. Resources for ASHE members include a comparison of guidance from various organizations on RPTs, a chart explaining the differences between RPTs and special purpose RPTs, and a sample RPT policy that can be adjusted to fit your facility's needs.

**NFPA 99 risk assessment tool:** This tool can help health care facility professionals comply with the risk-based approach required by the 2012 edition of NFPA 99: *Health Care Facilities Code*. The 2012 edition includes a major change to previous editions of NFPA 99. Previously, NFPA 99 applied different requirements based on occupancy type rather than on the risk to patients. The 2012 edition gives the same requirements for a procedure no matter where it takes place. This new approach gives hospitals more flexibility while maintaining safety.

This approach may seem more complex since it involves determining risk for multiple areas and multiple pieces of equipment, but risk assessment tools can help health care facilities keep track of the risk categories. ASHE created a Microsoft

Excel-based risk assessment tool that tracks equipment, system, and emergency management categories. To download the tool, you must submit your name and e-mail address so that ASHE can contact you if the tool is updated.

**FSES tool:** ASHE created this tool for hospitals that want to use a fire safety evaluation system (FSES) using the alternative compliance approach under NFPA 101A. Like the NFPA 99 risk assessment tool, you must submit your name and e-mail address to download the tool.

**Hazard vulnerability assessment tools:** ASHE published two tools last year to help hospitals assess and weigh potential hazards and their effects. Performing a hazard vulnerability analysis (HVA) is an important part of emergency preparedness, and these tools can help you refine your facility's emergency preparedness plans.

**Conference recordings:** ASHE has made conference recordings from select sessions available online. Members can watch these on-demand presentations to learn about topics including code compliance issues.

To access these new tools and explore other resources available to ASHE members, visit the ASHE Resource Library at [www.ashe.org/resource-library](http://www.ashe.org/resource-library). The library includes advocacy alerts, codes and standards guidance, articles, white papers, monographs, video recordings, checklists, tools, and sample policies.

You can search the Resource Library using key words and use drop-down menus to filter results.



# What you need to know about power strips

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

On September 26, 2014, the Centers for Medicare & Medicaid Services (CMS) issued S&C 14-46 LSC, Categorical Waiver for Power Strips Use in Patient Care Areas. This categorical waiver became necessary because of conflicts between the 1999 and 2012 editions of NFPA 99: *Health Care Facilities Code*. The 1999 edition of NFPA 99 is cross-referenced in the 2000 LSC and, as a result, contains requirements applicable to providers and suppliers who must meet CMS regulations. The 1999 edition of NFPA 99 Section 3-3.2.1.2 (d)-2 states: “Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters,” thus disallowing the use of multiple outlet adapters, better known as power strips, in patient care areas. By contrast, the 2012 edition of NFPA 99 has removed this requirement and allows the use of power strips in “patient care rooms,” which was the terminology that replaced the term “patient care area” used in the 1999 edition.

As allowed by the NFPA 101: *Life Safety Code*®, CMS may waive specific provisions of the 2000 edition of the LSC which, if rigidly applied, would result in unreasonable hardship, but only if the waiver does not adversely affect the health and safety of patients. CMS determined that the 1999 edition of NFPA 99 contains provisions on the use of power strips in health care facilities that may result in unreasonable hardship and for which an adequate alternative level of protection may be achieved by compliance with the 2012 edition of the LSC. Regulation S&C 14-46 LSC allows for the use of power strips in existing and new health care facility patient care areas/rooms, if the provider or supplier complies with all applicable 2012 NFPA 99

power strip requirements and all other 1999 NFPA 99 and 2000 LSC electrical system and equipment provisions. As listed in the S&C letter, the categorical waiver has the following specific requirements:

- Patient bed locations in new health care facilities, or in existing facilities that undergo renovation or a change in occupancy, shall be provided with the minimum number of receptacles as required by 2012 NFPA 99 Section 6.3.2.2.6.2.
- Power strips may be used in a patient care vicinity to power rack-, table-, pedestal-, or cart-mounted patient care-related electrical equipment assemblies, provided all of the following conditions are met, as required by 2012 NFPA 99 Section 10.2.3.6:
  1. The receptacles are permanently attached to the equipment assembly.
  2. The sum of the ampacity of all appliances connected to the receptacles shall not exceed 75 percent of the ampacity of the flexible cord supplying the receptacles.
  3. The ampacity of the flexible cord is suitable in accordance with the current edition of NFPA 70: *National Electrical Code*®.
  4. The electrical and mechanical integrity of the assembly is regularly verified and documented through an ongoing maintenance program.
  5. Means are employed to ensure that additional devices or nonmedical equipment cannot be connected to the multiple outlet extension cord after leakage currents have been verified as safe.





- Power strips may not be used in a patient care vicinity to power non-patient care-related electrical equipment (e.g., personal electronics).
- Power strips may be used outside of the patient care vicinity for both patient care-related electrical equipment and non-patient care-related electrical equipment.
- Power strips providing power to rack-, table-, pedestal-, or cart-mounted patient care-related electrical equipment assemblies are not required to be an integral component of manufac-

turer tested equipment. Power strips may be permanently attached to mounted equipment assemblies by personnel who are qualified to ensure compliance with 2012 NFPA 99 Section 10.2.3.6.

- Resident rooms in long-term care or other residential care facilities that do not use line-operated patient care-related electrical equipment are not subject to the more restrictive 2012 NFPA 99 requirements regarding the use of power strips in patient care areas/rooms.
- Resident rooms using line-operated patient care-related electrical equipment in the patient care vicinity must comply with the 2012 NFPA 99 power strip requirement and may elect to use this categorical waiver.
- If power strips are used in any manner, precautions as required by the LSC and reference documents are required, including but not limited to: installing internal ground fault and over-current protection devices; preventing cords from becoming tripping hazards; connecting devices so that tension is not transmitted to joints or terminals; not “daisy chaining” power strips; using power strips that are adequate for the number and types of devices; and not overloading power strips with high-load devices. In addition, the use of ground fault circuit interruption (GFCI) may be required in locations near water sources to prevent electrocution.
- Power strips providing power to patient care-related electrical equipment must be special purpose relocatable power taps (SPRPT) listed as UL 1363A or UL 60601-1.
- Power strips providing power to non-patient care-related electrical equipment must be relocatable power taps (RPT) listed as UL 1363.

A summary of the above requirements is provided in the following table.



## Summary of Appropriate Use of Power Strips in Designated Areas

Power Strip Type	Patient Care Vicinity	Patient Care Room	Non-Patient Care Room
SPRPT	A	A	A
RPT	N	A	A
Power strip	N	N	A

A = allowed; N = not allowed.

### Notes:

1. Power strips providing power to patient care-related electrical equipment in use with patients must be SPRPTs listed as UL 1363A or UL 60601-1 compliant.
2. Power strips providing power to non-patient care-related electrical equipment in patient care rooms must be RPTs listed as UL 1363 compliant.

To properly understand the requirements within the categorical waiver it is necessary to understand the difference between the various types of power strips. As noted in the summary table, there are three basic types of power strips 1) power strip, 2) Relocatable Power Tap, typically referred to as an RPT, and 3) Special Purpose Relocatable Power Tap or an SPRPT. The difference between these devices is the listing for which the device is approved; in other words, the best way to distinguish between similar-appearing devices is to check the listing mark on the device to determine the standard number with which it is to comply.

Devices that meet the requirements of UL 1363A or UL 60601-1 are considered to be SPRPTs. UL 1363A covers devices rated 250 V AC or less, intended for indoor use only, with medical equipment, where the medical equipment is intended to be used in general patient care areas or critical patient care areas as defined by *National Electrical Code Article 517, Health Care Facilities*. UL 60601-1 applies to the safety of medical electrical equipment. Although UL 60601-1 is primarily concerned with safety, it does contain some requirements regarding reliable operations.

Devices that meet the requirements of UL 1363 are considered to be RPTs. UL 1363 establishes device requirements covering indoor use cord and plug connected rated 250 V AC or less and 20 Amperes or less. RPTs are for use as movable power supply connections for cord and plug connected electrical utilization equipment in accordance with the National Electrical Code.

Per the CMS categorical waiver, all other multiple outlet devices are to be considered power strips.

The following requirements are listed within the categorical waiver.

- If renovation or a change in occupancy occurs, the minimum number of receptacles required by the 2012 edition of NFPA 99 must be provided.
- Power strips may not be used in a patient care vicinity to power non-patient care-related electrical equipment. This requires that SPRPTs within the space intended for the examination and treatment of patients (i.e., patient care room) that extend 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extend vertically 7

feet, 6 inches above the floor be dedicated to the use of patient care-related equipment and not be used to power other items such as personal electronics.

- Power strips being used outside of the patient care vicinity may be used for both patient care-related and non-patient care-related electrical equipment.
- Power strips do not have to be permanently mounted, but if they are they must be mounted by personnel who are qualified to ensure compliance with Section 10.2.3.6 of the 2012 edition of NFPA 99.
- Power strips must be used safely.

- To be eligible to use power strips within patient care rooms, a formal election to use the waiver must be documented.
- Finally, at the entrance conference for any survey assessing LSC compliance, the survey team must be notified of this election. It is not acceptable for a healthcare facility to first notify surveyors of waiver election after a LSC citation has been issued.

ASHE has provided several resources to assist in the safe use of power strips and highly recommends that any facility electing to apply this categorical waiver establish a policy and procedure for power strip use. A sample policy is available to ASHE members on the ASHE Advocacy web page at [www.ashe.org/rpt](http://www.ashe.org/rpt).



# ASHRAE, ASHE work closely on finalizing *Legionella* standard

By **Deanna Martin** ASHE Communications Manager

The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) recently worked with ASHE to make significant progress toward a standard aimed at preventing legionellosis without being overly burdensome for health care facilities. ASHE congratulates ASHRAE for taking this common sense approach to keeping patients safe while recognizing the unique nature of health care facilities.

ASHRAE has been working on its new standard, Standard 188P, *Legionellosis: Risk Management for Building Water Systems*, for several years. The purpose is to establish minimum legionellosis risk management requirements for building water systems. ASHE as an organization and individual ASHE members have been part of the ASHRAE process from the beginning to ensure that the document recognizes the challenges, expertise, and procedures unique to the hospital environment.

The committee working on ASHRAE 188P met in December 2014 and January 2015 to review changes suggested from a total of 168 public comments received in 2014. Among the changes the committee approved is a separate appendix for qualifying health care facilities. The appendix provides an alternate risk assessment methodology to comply with the standard. This addition, stemming from ASHE's collaboration with ASHRAE, pertains to a specifically defined group of health care facilities in an effort to recognize the special qualities of the health care physical environment.

This separate appendix allows qualifying health care facilities to establish a designated team responsible for developing, implementing, and documenting all applicable requirements in the appendix.



Photo: Janice Haney Carr, Centers for Disease Control and Prevention

The changes approved in January are not yet final. Once all of the changes approved at the January committee meeting are incorporated into an ISC (independent substantive changes) document, the committee will vote on whether to approve the ISC document for publication. The document will then need to be approved by the Standards Project Liaison Subcommittee of the ASHRAE Standards Committee and be sent out for an additional public review exclusive to the incorporated changes, which closed for public comment on April 12, 2015. Once these comments have been reviewed and addressed the proposed standard will be finalized and issued. It is anticipated that the standard could be finalized and approved by ASHRAE's annual meeting, which will take place in Atlanta, June 27 through July 1.

Once approved by ASHRAE, the standard will be published and available for adoption by jurisdictions, thus making the standard enforceable. Please watch for the upcoming public review opportunity to see the latest version of Standard 188P.

ASHE will continue to keep members posted about the latest developments with this important standard.



# ASHE advocacy works to protect wireless patient monitoring

By **Deanna Martin** ASHE Communications Manager

ASHE's advocacy work goes beyond representing members on codes and standards issues. For example, one advocacy issue deals with the protection of wireless medical telemetry devices for monitoring patient health.

The Federal Communications Commission (FCC) regulates the spectrum used for wireless medical telemetry devices. Technological advances in recent years have created greater demand for spectrum space for commercial applications and other uses, and the FCC has been under pressure to find additional spectrum space.

The FCC set out to consolidate unused TV channels, repacking them to open up more spectrum space. A large portion of hospital medical telemetry devices operate on TV channel 37, which is not used by TV stations. When the FCC explored the possibility of moving hospital devices away from channel 37 to another bandwidth a few years ago, ASHE stepped in to advocate on behalf of hospitals.

The U.S. Congress allocated \$300 million to relocate medical telemetry devices and radio astronomy installations from channel 37. But hospital telemetry equipment cannot be easily retuned to a new frequency bandwidth; such a move would require thousands of hospitals to throw away existing equipment and purchase new equipment designed for the new spectrum space. ASHE calculated that such a move would cost health care \$2.6 billion.

ASHE worked with lawyers, engineers, and other stakeholders to explain the situation to the FCC and suggest alternatives. ASHE stressed to the FCC the patient safety implications, submitted public comments during the FCC rulemaking process, and met with each FCC commissioner to make plain the need for reliable patient monitoring.

ASHE had previously developed a relationship with the FCC through discussions about wireless telemetry, and ASHE had been assigned to handle registration of wireless medical telemetry devices as frequency coordinator of the Wireless Medical Telemetry Service (WMTS). Because of ASHE's relationship with the FCC, the Society had a seat at the table and could communicate directly with the policy makers during these important discussions.

In 2014, the FCC issued a rule ensuring that WMTS devices may continue to operate on channel 37—a major victory for hospitals. ASHE's advocacy helped hospitals continue their work in patient monitoring and remote telemetry.

ASHE is still working closely with the FCC on wireless medical telemetry issues, including setting technical parameters that will protect devices on channel 37 from interference from other devices. In May of 2015, ASHE encouraged members to urge the FCC to prioritize patient care over other interests. ASHE will continue to advocate on behalf of hospitals and patients on this issue, which will become even more important as medical technology advances and available spectrum space contracts.

To be protected from interference from other devices, hospitals using wireless medical telemetry devices must register with ASHE, the designated WMTS frequency coordinator. Registered systems must be kept up to date, so be sure to report if your system information changes. To find out whether your facility is registered or to update your registration, visit [www.ashe.org/wmts](http://www.ashe.org/wmts).

# Helping members fine-tune facilities

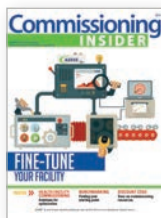
By **Deanna Martin** ASHE Communications Manager

Health facility commissioning is a process that examines the complex systems included in health care facilities to make sure they are performing as designed. The process can be used during new construction or on existing facilities, and is becoming more important as hospitals face increasing pressure to cut operational expenses.

ASHE has recognized the value of commissioning for years and has advocated for the incorporation of commissioning principles into codes and standards. For example, the 2014 Facility Guidelines Institute *Guidelines for Design and Construction of Hospitals and Outpatient Facilities* states that, at a minimum, the following systems are to be commissioned for projects that involve “installation of new or modification to existing physical environment elements critical to patient care and safety or facility energy utilization”: HVAC, automatic temperature control, domestic hot water, fire alarm and fire protection systems, and essential electrical power systems.

Aside from compliance with regulations, commissioning can help hospitals save significant resources by ensuring that systems are running as they should. Several commissioning standards exist, but ASHE recommends that hospitals use the ASHE commissioning process, which is health care-specific and incorporates the unique challenges of health care facilities. To learn more about commissioning, ASHE offers several resources:

- **Commissioning magazine:** The *Commissioning Insider* magazine produced by ASHE outlines the benefits of commissioning as well as how-to articles and other useful information. Members are sent a copy of the print magazine, or you can read an online version by searching the ASHE Resource Library at [www.ashe.org/resourcelibrary](http://www.ashe.org/resourcelibrary).



- **Commissioning course:** ASHE’s commissioning course teaches attendees how to develop a business plan that presents the value of health facility commissioning to executive leaders and demonstrate the return on investment that comes from embracing the health facility commissioning process. The class also explores critical aspects of the process, with emphasis placed on a collaborative effort that brings together the health care organization, design team, constructors, and commissioning agent. The course also shows how the process can be scaled to projects of various sizes. Visit [www.ashe.org/learn](http://www.ashe.org/learn) and click on health facility commissioning to learn more and see the schedule of courses. To learn more about hosting this program for your ASHE chapter or other group, contact ASHE at [ashe@aha.org](mailto:ashe@aha.org).
- **Commissioning guidelines:** To tailor the commissioning process specifically to complex hospitals and other health care facilities, ASHE created the *Health Facility Commissioning Guidelines*. This resource establishes a standard process for commissioning health care facilities and stresses a collaborative approach among project participants. This document is available as a print or e-book edition at [www.ashestore.com](http://www.ashestore.com).
- **Commissioning handbook:** The *Health Facility Commissioning Handbook* provides step-by-step instructions for implementing the health facility commissioning process outlined in the *Health Facility Commissioning Guidelines*. The handbook also includes information to help facility managers and others communicate the importance of commissioning and show the return on investment the process can bring. This resource is available as a print or e-book edition at [www.ashestore.com](http://www.ashestore.com).

# Barrier management key to compliance

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

A significant concern in the physical environment of health care facilities is the continued occurrence of survey findings regarding the Environment of Care and Life Safety Chapters in the Joint Commission's Hospital Accreditation Program. Eight of the top ten most often scored standards represent a total of 137 elements of performances within these chapters. To improve the awareness of one of the top cited issues—barrier management—ASHE has collaborated with the Joint Commission, Underwriters Laboratory, and the Firestop Contractors International Association in the development of the Barrier Management Symposium—a one-and-a-half-day symposium that addresses the design, installation, inspection, and maintenance of barrier systems.

Fire and smoke barriers installed in buildings are living elements of the structure. They protect healthcare building occupants and are used for horizontal evacuation of compromised areas. These barriers and their features form effective compartmentation that allows for defend-in-place strategies. Fire and smoke barrier management is critical to maximize patient safety and property protection; minimize death and injury; and facilitate entry and travel in structures for emergency responders.

The Barrier Management Symposium focuses on the proper DIIM—design, installation, inspection, and maintenance—of fire and smoke barrier systems, which ensures that the defend-in-place practice in healthcare facilities works when it is called on. The Barrier Management Symposium program educates attendees about the testing that qualifies products for use; code requirements for installation and inspection; proper design applications of systems, and management and maintenance for ongoing reliability of the installed fire resistance rated and smoke resistant products.



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

These features become a reliable system when they are properly “DIIM”-ed.

The Symposium is designed to increase the awareness of the healthcare engineering professional of the value of barrier management systems as well as their understanding of the underlying keys to long-term success. To date, more than 650 professionals have attended the five symposiums, which have been delivered on an ASHE regional basis. An additional four symposiums are being scheduled and planned for 2015, and the final regional symposium is anticipated at the beginning of 2016. The symposium has gained popularity and may have had an effect on the reduction of findings over the last year. During 2014, a decrease in the amount of citations within the relative Life Safety Standards has helped to move standards related to barrier management further down on the Top 10 list. There is still a need to increase awareness of this issue on a local chapter level. A single-day chapter-level program is expected to be available toward the end of 2015. To coordinate a regional or chapter presentation, please contact me, Jonathan Flannery, ASHE Senior Associate Director of Advocacy, at [jflannery@aha.org](mailto:jflannery@aha.org).



# Six tips for making local ASHE advocacy work

By Ed Avis

When the Washington State Department of Health (DOH) decided in 2006 to adopt the Facility Guidelines Institute (FGI) *Guidelines for Design and Construction of Health Care Facilities* as the standard for health care facility construction in the state, the agency wanted to make sure the *Guidelines* fit the particular needs of Washington State. Such adaptation is common when states adopt national guidelines.

The DOH did not undertake the task in a vacuum; the ASHE-affiliated chapter in the area, the Washington State Society for Healthcare Engineering (WSSHE), stepped up and provided essential guidance.

“We had cultivated over the years a great relationship between the Department of Health and our professional association,” said Geoff Glass, director of facility and technology services for Providence St. Peter Hospital in Olympia, Washington, and a leader of WSSHE. “If not for the mutual respect between WSSHE and the Department of Health, this would not have been possible.”

The efforts of WSSHE to ensure that Washington State requirements truly reflected the situation in the state, an example of how local ASHE chapters can advocate for their needs.

## ASHE needs help with advocacy issues

ASHE members are typically busy professionals with little spare time, but the potential payoff from the time spent on advocacy issues is well worth it, according to Chad Beebe, who managed the Washington DOH Construction Review Services program when the state adopted the FGI *Guidelines* and who is now ASHE’s deputy executive director of advocacy.

Beebe remembers the relationship with WSSHE well. He says WSSHE’s suggestions and efforts were the key to the success of the FGI *Guidelines* adoption (see the sidebar for more information on WSSHE’s efforts).

The success in Washington is not the only recent success. Many members of ASHE-affiliated chapters in Washington and Oregon recently testified at hearings on crucial code changes in Portland, Oregon. Beebe believes their testimony led to successful results.

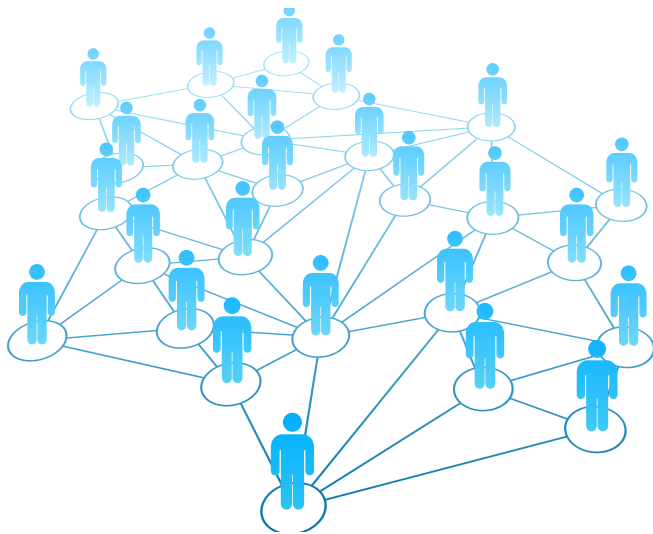
“We need more grassroots advocacy,” Beebe said. “Grassroots advocacy is a method for local chapters of associations like ours to harness the thoughts and ideas of members when issues arise. Grassroots advocacy is possibly one of the most effective methods of advocacy, but unfortunately one that we don’t always do well.”

## Getting out the vote

Recently a code change was proposed that Beebe believes could have improved delivery of patient care and saved the health care field valuable resources. Unfortunately, the change failed to pass, though more input from ASHE members may have led to a different result.

“We have had several issues over the years that get challenged in the code hearings and come down to a vote,” Beebe said. “Unfortunately, we typically are not able to sustain the numbers to carry those votes.”

ASHE members may cite many reasons why becoming more active in advocacy is difficult. Many facility professionals do not have travel funds available through their organizations. Some members use education funds to attend National Fire



Protection Association (NFPA) education sessions, but don't have the budget to stay another day when the voting session occurs, and thus, their voices are not heard at the crucial moment.

Some members feel that only large businesses can affect codes, but Beebe disagrees. "It's easy to point the finger at industry, but every stakeholder has the opportunity to be a part of the process," Beebe said. "The work leading up to the membership votes in processes such as NFPA is very balanced and consensus driven. If you exclude those who may have a dissenting opinion, you don't get a very good code. Unfortunately, those that spend the time, effort, and investment to be involved are the ones that are able to make change happen. There is no reason we can't control our own destiny in the codes arena."

### ASHE sets the stage

According to Beebe, many members seem to believe that the national ASHE office handles all advocacy initiatives, but the work of ASHE staff is only part of the effort. The ASHE advocacy team also sets the stage for members to speak up.

"We provide the conduit for our members to be heard," Beebe said. "Members still need to get

involved on national, state, and local issues. Likely you are a master advocate and don't even know it. You have probably advocated for your department, the number of FTEs, budget, pay raises, and more. You have likely been successful more often than not. An advocate is someone that supports or recommends a particular cause or policy. All of us have some ability to advocate."

### Six tips to make grassroots advocacy work

Below are six tips Beebe suggests for making advocacy work:

1. **Communicate:** Discussing advocacy issues with your colleagues is a good first step. Hear everyone's thoughts, and listen to opposing voices as closely as to voices of those who agree with you. A strong position looks at both pros and cons and acknowledges differing opinions.
2. **Develop a position:** Take the information from your discussions and refine your position. Base your ideas on facts, and consider solutions to the problems. Make positive outcomes the focus of your position.
3. **Act:** Identify people who can make the changes you seek, and let them know about your position. If the issue you are addressing deals with law, identify key legislators. Remember that your hospital is probably the largest employer in their district—legislators will want to listen to what you have to say. Provide policy and decision makers with facts that clearly and concisely show the impact of your issue and how your suggested changes can improve the situation.
4. **Make alliances:** Identify other stakeholders who have similar interests. Fellow stakeholders may include a state hospital association, local American Institute of Architects group or engineering groups, general contractors associations, and so forth. They probably have similar advocacy programs and may be willing to support you.

**5. Follow up:** Make sure the people you are working with receive the information you send them and that they hear your message. Ask them if they have questions and be prepared with solid answers that back up your position.

**6. Don't go away:** There is truth to the adage that “the squeaky wheel gets the grease.” People who ardently advocate for their position are much

more likely to see results than those who don't. Show your true passion for your issues and remind people that you are looking for results, not lip service.

“We absolutely count on chapter members to be the primary advocates for issues at the state and local level, and they really do make a difference,” Beebe said.

### **ASHE-affiliated chapter in Washington guides the *Guidelines***

The ASHE-affiliated chapter in Washington State (WSSHE) did not sit on the sidelines when the Washington State Department of Health adopted the FGI *Guidelines* in 2006. Fortunately, the chapter and leaders in the DOH already had a good relationship, so WSSHE was ready to step in and make sure the people on the front lines of hospital facilities management were heard.

“Really the effort began long before the 2006 code was printed,” said Chad Beebe, who managed the Washington DOH Construction Review Services program when the state adopted the FGI *Guidelines* and who is now ASHE's deputy executive director of advocacy.

WSSHE began holding quarterly meetings at which chapter members examined the FGI *Guidelines* and decided which provisions needed to be edited to fit the state's needs.

“We brought in representatives from the State Department of Health and representatives from health care facilities, as well as the architects and engineers who design our facilities,” said Geoff Glass, director of facility and technology services for Providence St. Peter Hospital in Olympia, Washington, and a leader of WSSHE.

The group broke into small working groups and reviewed each provision. Key positions on the issues were developed, and the groups refined the language of each revision and submitted them to the DOH, along with anecdotes or metrics to back up each change. The DOH considered the changes, edited the *Guidelines* as needed, and formally adopted them.

“My sense was that they listened to us,” Glass said. “Several amendments were made to the *Guidelines* that bore a lot of resemblance to what we had submitted.”

Glass says the process demonstrated the value that on-the-ground experts can provide to the regulatory process.

“I look at our hospitals as basically reality laboratories,” he said. “They're the proving ground of what works and what doesn't. That's wonderful wisdom to provide to regulators.”

Beebe agrees. “The feedback from so many people like Geoff really shaped the 2006 edition.”



# Save the date: 2017 NFPA meeting is vital

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

It may seem far down the road, but now is the time to begin planning to attend the 2017 National Fire Protection Association (NFPA) Conference & Expo. The NFPA Conference and Technical Meeting will be held June 4 through 7, 2017, at the Boston Convention and Exhibition Center.

Why should you plan now to attend a technical meeting two years away? All of the NFPA technical meetings are important, because at these meetings code changes are brought up for a vote. The 2017 meeting is especially important because several years ago a change was made to move NFPA 99 and NFPA 101 into the same code development cycle. The next opportunity to review these important health care documents is in 2017, and changes made in 2017 will be incorporated into the 2018 editions.

Focusing on the 2018 edition can seem difficult when hospitals are currently using the 2000 and 1999 editions of these documents and are just now discussing the move to the 2012 edition. However, we must treat every document as if it is going to be adopted. NFPA 99 is often incorporated into the *International Building Code*, so every edition is important and could pose significant hardships on your facility should an unnecessary or overly burdensome requirement slip through.

ASHE has been working hard to align all of the various codes and standards to have less overlap, fewer gaps, and fewer code conflicts. This work doesn't happen over one code development cycle, however. Aligning the codes is a long process that occurs over several editions. Each code cycle is a chance for negotiations with code development

committees to draw the boundary lines between codes to ensure that the codes don't overlap, which is where most of the conflicts occur. To maintain these boundaries, continuous involvement in the development of the codes and standards is necessary.

Provisions that are entered into the codes tend to remain in the codes for some time. When the time comes to adopt new editions of the code, removing provisions can be difficult even if they don't make much sense, because they are already written into the codes.

## Your vote counts

For these reasons, ASHE fights for unified codes and standards based on science in every edition of codes that are developed. Even though the adoption of the 2005 edition was in question, ASHE still opposed several issues; unfortunately, ASHE failed to prevent the provisions from being added because of insufficient membership support at the hearings. More recently, ASHE tried to align the *Life Safety Code*® with the *International Building Code*, which just revised its long-standing smoke compartment size limitation from 22,500 square feet to 40,000 square feet. ASHE advocacy successfully lobbied to have this changed in the *Life Safety Code*. Despite a massive campaign by ASHE to call members into action and attend the 2014 Technical Meeting, not enough hospital members attended the meeting and voted, and an appeal was upheld to revert the code back to 22,500 square feet.

ASHE is now learning of issues and concerns with the 2012 edition of NFPA 99 that resulted from

the meetings held in 2004. ASHE also advocated very hard at those meetings but did not have the membership to support the final floor actions. One of these provisions dealt with wet locations. ASHE testified against the new provision to make all operating rooms (new and existing) wet locations unless a risk assessment is performed. Unfortunately we lost that vote, as only a handful of people were there to testify and, more importantly, vote.

The investment of \$1,500 to \$3,000 it would have taken for you to attend the Technical Meeting could have prevented the \$20,000+ per operating room now required for hospitals to install isolated power systems. Granted, in some locations such systems are appropriate for the safety of the staff and patients, but we believe that assessment has already been done, and has been in place for some time at hospitals. This change in requirements now allows authorities to question the assessment protocols and documentation used by facilities and requires those facilities to retroactively install such



systems even if no hazard or risk has been identified in the operating room.

### **Get involved in your future today**

Make sure your NFPA membership is up to date (visit [www.nfpa.org/join](http://www.nfpa.org/join)) so that you can attend the meeting and cast your critical vote on issues at the 2017 NFPA Technical Meeting in Boston. Watch future ASHE emails for calls to action on issues as they come up. We will set the stage for better codes and standards, but we need your voice and your vote to make it happen.

# Get involved and reap personal, professional, and industry benefits

By **Lynn Kenney** ASHE Senior Analyst for Advocacy

ASHE's advocacy volunteers and others who volunteer with the Society often comment that the experiences they have as volunteers are some of the most rewarding experiences of their careers. Volunteers have the opportunity to improve the health care physical environment while exchanging knowledge with others and increasing their professional network. Get involved with ASHE today to take advantage of the personal and professional benefits of volunteering while helping the field advance.

Volunteering to help with advocacy work is especially important. The regulatory environment continues to change and evolve, but with the help of volunteers, ASHE is making progress toward the goal of unified codes and standards. Every dollar spent to comply with conflicting or outdated codes is a dollar hospitals don't have for the healing environment or patient care. Involvement with advocacy initiatives helps change that—whether volunteers are participating in industry events or working with ASHE to monitor and improve the hundreds of codes and standards that regulate health care. Strong relationships and effective communication with all the stakeholders, from ASHE members to lawmakers, ensure our ability to improve health care regulation.

Consider getting involved with ASHE in the following ways:

- Volunteer with ASHE by submitting an application to the ASHE volunteer database. You can highlight your skills and interests and will be considered for volunteer positions or special task force assignments. Visit [www.ashe.org/volunteer](http://www.ashe.org/volunteer).
- Share your expertise with other ASHE members by submitting a publication idea for an article in *Inside ASHE* magazine, an ASHE monograph, or another publication. Visit [www.ashe.org/publish](http://www.ashe.org/publish).
- Share case studies or other information at the ASHE Annual Conference and Technical Exhibition and the International Summit & Exhibition on Health Facility Planning, Design & Construction (PDC Summit) by submitting a session proposal during the “call for presentations.” Watch [www.ashe.org](http://www.ashe.org) for more information on the call for presentation timelines.

**If you have any questions about volunteering or need more information, please contact Lynn Kenney at [lkenney@aha.org](mailto:lkenney@aha.org).**

# Education helps members stay up to date on changing issues

By Patrick J. Andrus, MBA, CAE ASHE Deputy Executive Director of Operations

As a membership organization, ASHE is guided by its mission to optimize the health care physical environment. Advocacy is one part of this mission, and ASHE's education portfolio is another key pillar of the organization. ASHE's learning opportunities continue to grow and evolve as ASHE works to increase the knowledge and skills of its members in a rapidly changing health care environment.

Tim Adams, FASHE, CHFM, CHC, director of leadership development with ASHE, believes health care is a people business. "ASHE's portfolio of education opportunities and products addresses a plethora of aspects of designing, building, and managing the physical health care environment, yet the heart of ASHE education are those who ultimately use health care facilities; the focus is providing a safe, comfortable, efficient, and compassionate environment in which care is delivered," he said.

ASHE is focused on developing programs and content that meet evolving needs of health facility professionals. Programs include subjects such as health facility planning, design, and construction, operations and maintenance, codes and standards, and leadership development. In response to member feedback, ASHE started a new track at the International Summit & Exhibition on Health Facility Planning, Design & Construction (PDC Summit) and the ASHE Annual Conference & Exhibition to focus on delivering value to the executive level. Session topics ranged from retaining market share through repurposing facilities to reducing PDC cost structure to understanding what the C-suite wants.

In addition to expanding content, ASHE is diversifying the delivery of educational programming to meet the needs of members. For example, ASHE is beginning to take education programs to clients at their own facilities. While ASHE still holds seminars around the country, organizations that meet certain criteria have the opportunity to bring ASHE programming directly to their site for training. This reduces the travel costs to the participants, and, in many cases, allows ASHE to target the specific training needs of the organization.

While in-person training is still sought by members, new technology for education delivery allows ASHE to explore new ways to transfer knowledge to its membership. ASHE is extending learning opportunities through its existing member magazine, *Inside ASHE*. As a top ranked benefit, *Inside ASHE* is delivered to members in print and digital format every quarter. The magazine now offers continuing education units (CEUs) at no additional cost to ASHE members. Readers take a brief online quiz on the articles in the current issue and can print out the CEUs earned once completed. ASHE also recently worked with the Facility Guidelines Institute (FGI) to create a customizable e-learning program about the FGI *Guidelines*.

ASHE's seminars have had a tremendous impact in the field. In 2014, ASHE's programs were attended by 8,417 industry professionals, which totaled 74,456 total hours of education delivered. To learn more or to register for ASHE's 2015 programs, visit [www.ashe.org/learn](http://www.ashe.org/learn).



# On the radar: ASHE monitors hundreds of regulations

By Lynn Kenney ASHE Senior Analyst for Advocacy

More than 100 different regulations apply to the construction, inspection, or maintenance of healthcare facilities. Codes and regulations from the National Fire Protection Association (NFPA), American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), International Code Council (ICC), Facility Guidelines Institute (FGI), U.S. Pharmacopeial Convention (USP), Americans with Disabilities Act (ADA), Occupational Safety and Health Administration (OSHA), the Centers for Medicare & Medicaid Services (CMS), and others are continuously moni-

tored to maintain a proactive advocacy position in support of regulations that are backed by data and science and make sense for health care.

Below is a partial list of the regulations currently on ASHE's radar screen. ASHE is always looking for knowledgeable individuals to represent the Society and its members on the many committees that create and update the code and standards and regulations that affect health care facilities.

If you are interested in getting involved, email Lynn Kenney at [lkenney@aha.org](mailto:lkenney@aha.org). We look forward to your participation!

Document No.	CODE TITLE	SCOPE OF DOCUMENT or COMMITTEE
NFPA 10	Standard for Portable Fire Extinguishers	Covers the selection, installation, inspection, maintenance, and testing of portable extinguishing equipment.
NFPA 13	Standard for the Installation of Sprinkler Systems	Covers sprinkler system design, installation, and acceptance testing; hanging and bracing systems; underground piping; and seismic protection in line with SEI/ASCE 7.
NFPA 25	Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems	The Standard governs the periodic inspection, testing, and maintenance of water-based fire protection systems
NFPA 30	Flammable and Combustible Liquids Code	Provides safeguards to reduce the hazards associated with the storage, handling, and use of flammable and combustible liquids
NFPA 70	National Electrical Code®	Addresses the installation of electrical conductors, equipment, and raceways; signaling and communications conductors, equipment, and raceways; and optical fiber cables and raceways in commercial, residential, and industrial occupancies.
NFPA 72	National Fire Alarm and Signaling Code	Covers the application, installation, location, performance, inspection, testing, and maintenance of fire alarm systems, supervising station alarm systems, public emergency alarm reporting systems, fire warning equipment and emergency communications systems (ECS), and their components
NFPA 80	Standard for Fire Doors and Other Opening Protectives	Regulates the installation and maintenance of assemblies and devices used to protect openings in walls, floors, and ceilings against the spread of fire and smoke within, into, or out of buildings
NFPA 90A	Standard for the Installation of Air-Conditioning and Ventilating Systems	Covers construction, installation, operation, and maintenance of air conditioning and ventilating systems, including filters, ducts, and related equipment, to protect life and property from fire, smoke, and gases resulting from fire or conditions having manifestations similar to fire

Document No.	CODE TITLE	SCOPE OF DOCUMENT or COMMITTEE
<b>NFPA 99</b>	Health Care Facilities Code	Establishes criteria for levels of health care services or systems based on risk to the patients, staff, or visitors in health care facilities to minimize the hazards of fire, explosion, and electricity
<b>NFPA 101</b>	Life Safety Code®	Provides for all types of occupancies, with requirements for egress, features of fire protection, sprinkler systems, alarms, emergency lighting, smoke barriers, and special hazard protection
<b>NFPA 101A</b>	Guide on Alternative Approaches to Life Safety	Procedures for determining equivalency with Life Safety Code requirements
<b>NFPA 110</b>	Standard for Emergency and Standby Power Systems	Covers performance requirements for emergency and standby power systems providing an alternate source of electrical power in buildings and facilities in the event that the normal electrical power source fails
<b>NFPA 111</b>	Standard on Stored Electrical Energy Emergency and Standby Power Systems	Covers performance requirements for stored electrical energy systems providing an alternate source of electrical power in buildings and facilities in the event that the normal electrical power source fails
<b>ASHRAE 170</b>	Ventilation of Health Care Facilities	Defines ventilation system design requirements that provide environmental control for comfort, asepsis, and odor in health care facilities.
<b>ASHRAE 189.3</b>	Design, Construction and Operation of Sustainable High Performance Health Care Facilities	Prescribes the procedures, methods, and documentation requirements for the design, construction, and operation of high performance sustainable health care facilities.
<b>ASHRAE AEDG</b>	Advanced Energy Design Guides	Provides recommendations for achieving energy savings over the minimum code requirements of ANSI/ASHRAE/IESNA Standard 90.1
<b>ASHRAE 188P</b>	Legionellosis: Risk Management for Building Water Systems	Presents practices for the prevention of legionellosis associated with building water systems
<b>IBC</b>	International Building Code®	Establishes the minimum requirements to safeguard the public health, safety and general welfare through structural strength, means of egress facilities, stability, sanitation, adequate light and ventilation, energy conservation, and safety to life and property from fire and other hazards attributed to the built environment and to provide safety to fire fighters and emergency responders during emergency operations.
<b>IFC</b>	International Fire Code®	Regulates minimum fire safety requirements for new and existing buildings, facilities, storage and processes. The IFC addresses fire prevention, fire protection, life safety and safe storage and use of hazardous materials in new and existing buildings, facilities and processes.
<b>IgCC</b>	International Green Construction Code™	Provides a vehicle for jurisdictions to regulate green for the design and performance of new and renovated buildings that is integrated with existing codes, includes ANSI/ASHRAE/USGBC/IES Standard 189.1
<b>Health Guidelines Revision Committee (HGRC) of the Facility Guidelines Institute</b>	Guidelines for Design and Construction of Hospitals and Outpatient Facilities	Contains information intended as minimum standards for the design and construction of new health care facilities and major renovations of existing health care facilities, includes ASHRAE 170

# Accessing the codes and standards information you need

ASHE offers several resources to help members stay in compliance with various codes and standards regulating the health care physical environment. The resources listed below highlight some of the ways to access guidance and information available for members.

- **Resource Library:** The ASHE Resource Library is a centralized spot to find ASHE resources, including magazine articles, advocacy alerts, issue briefs, monographs, tools, checklists, and other information. You can search by keyword or use filters to search for specific topics or types of resources. Visit [www.ashe.org/resourcelibrary](http://www.ashe.org/resourcelibrary) to search or browse for information of interest to you.
- **ASHE Management Monographs:** These monographs cover single topics in compliance, facility engineering, planning and construction, facility management, clinical and biomedical engineering, safety and security, emergency preparedness, infection prevention, and more. ASHE members can access the monographs and download a PDF copy for free. Print copies are also available. Visit [www.ashe.org/resources/management\\_monographs](http://www.ashe.org/resources/management_monographs) or go to the Resource Library to find monographs.
- **Conference recordings:** ASHE members have access to selected recordings from previous conferences, including the ASHE Annual Conference and the PDC Summit. Online recordings cover topics such as compliance strategies, fundamentals, leadership, and operational excellence. The conference recordings can be found in the Resource Library and they are also available at [www.ashe.org/resources/conference\\_recordings](http://www.ashe.org/resources/conference_recordings).
- **Issue briefs and advocacy alerts:** ASHE e-mails issue briefs and advocacy alerts to members to keep them up-to-date on the latest developments. Issue briefs explain an advocacy issue, such as a new policy from the Centers for Medicare & Medicaid Services. Advocacy alerts explain an issue and ask members to complete an action, such as submitting public comments to a new proposed version of NFPA 101. Issue briefs and advocacy alerts are sent directly to members and are also available in the ASHE Resource Library.
- **ASHE news:** ASHE members receive a weekly e-mail newsletter, the ASHE Insider, which includes a codes and standards section. Stories alert members of new code developments and often ask members to get involved with advocacy efforts. The newsletter is e-mailed directly to members and past stories are available at [www.ashe.org/ashenews](http://www.ashe.org/ashenews). ASHE's quarterly print magazine, Inside ASHE, often features articles on advocacy or code topics. The magazine is mailed directly to members, and past stories can be found in the ASHE Resource Library or at [www.ashe.org/resources/inside\\_ASHE](http://www.ashe.org/resources/inside_ASHE).
- **ASHE LISTSERV®:** The ASHE LISTSERV provides members a chance to communicate with other members via an e-mail LISTSERV. Members often discuss advocacy issues and ask each other questions about compliance information. To sign up for the LISTSERV or learn more, visit [www.ashe.org/listserv](http://www.ashe.org/listserv). The LISTSERV is a members-only forum.

# ASHE Staff Directory

The ASHE staff can be a resource to help members. Below is a staff directory organized by job description.

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# 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.

As outlined in this publication, ASHE needs your help to create better codes and standards regulating health care facilities. To get involved, contact ASHE Deputy Executive Director of Advocacy Chad Beebe, AIA, SASHE, at [cbeebe@aha.org](mailto:cbeebe@aha.org).