It is time to roll out the red carpet to the NEHES Fall Conference taking place at the Holiday Inn by the Bay in downtown Portland, Maine on Sunday, September 29 through Wednesday, October 2, 2013.

The conference fee is $100 for Active, Associate, Educator/Student and Honorary Members. The conference fee for Supporting Members is $500 and for Non-Members, $600.

For those who hold certifications that require continuing education, the American Society of Healthcare Engineers has granted 11.5 contact hours, or 1.15 CEUs for this conference.

To register, go to NEHES.org.

Conference Sessions Include:

Monday 9/30/13:
- General Breakfast 7–8 AM
- Keynote Address: 8–9 AM Lessons Learned from the Boston Marathon Bombings Experience (SEE PAGE 6)
- Session 1 - 9:15–10:15 AM Bridging the Gap between Clinical and Non-Clinical
- Session 2 -10:30–11:30 AM Integrated Project Delivery— The MaineGeneral Medical Center Success Story
- Lunch and Technical Exhibits 11:30–3:30 PM Meet with our array of vendors to see the latest and greatest in equipment and services. Don’t miss this conference highlight!
- Session 3 – 3:30–4:30 PM - What You Should Know About Owner Based Commissioning
- Cocktail Hour 6–7 PM
- Buffet Dinner & Band 7–9 PM

Tuesday 10/1/13:
- General Breakfast 6:30–8 AM
- Track 1 -8:00—9 AM Surviving a CMS Accreditation Survey
- Track 2 -8:00—9 AM Fundamentals of a Green Roof
- Track 1-9:15—10:15 AM The Importance of Conducting A Comprehensive Preconstruction Risk Assessment
- Track 2- 9:15—10:15 AM Regulatory & Operational Facility Grid
- Track 1 -10:30—11:30 AM Optimizing Thermal Energy Management via Modular On-Demand Boilers
- Track 2 – 10:30—11:30 AM Air Distribution in Surgical Suites
- Lunch—11:30–12:30 PM
- Track 1 – 12:45–1:45 PM Something In The Air: What You Can’t See Can Hurt You
- Track 2 – 12:45–1:45 PM– How Chilled Water Optimization Makes Cogeneration More Effective
- Track 1— 2—3 PM The Life Safety Scorecard and Fire Drill procedure for New Codes
- Track 2 –2—3 PM Compliance With New Air Pollution Regulation for Boilers & Emergency Generators
- NEHES Annual Meeting— 3:45–5 PM
- Cocktail Hour 6–7 PM
- Awards Banquet 7–9 PM

Wednesday 10/2/13
- Continental Breakfast 7—7:45 AM
- Session 1 – 8:00—9 AM Concept to Operation—A Combined Heat and Power Plant
- Session 2 – 9:45—10:45 AM Updates from the Joint Commission
- Grab A Box Lunch and Safe Travels Home! - 11 AM

Important Hotel Room Information for the Fall Conference
The block of rooms are sold out at the Holiday Inn By the Bay.
A block of rooms has been reserved at the Merry Manor/Best Western at 700 Main Street in South Portland, ME. Call 207-774-6151 and book one of the New England Healthcare Engineers’ block of rooms.
Rate is $129.00 plus taxes.
Cut off date to book these rooms is September 12. Shuttle service will be provided to and from the conference site.
NEHES Secretary, Jona Roberts from Dartmouth-Hitchcock Medical Center was the ultimate host tending to every detail of the day long event.

“Control Central” in Auditorium E at the 225-acre medical center in Lebanon, NH.

Hallway discussions are a welcomed part of the Twin State Seminar.

Jack Conry from Fletcher Allen Healthcare discusses security in hospitals. (At left) Jack displays a homemade object found in a patient area. (Below) Conry shows other contraband to NEHES Board Member, Mark Blanchard, from Springfield Hospital (VT).

Maria Tatarczuk, Business Development Manager for RDK Engineers is drawn to the resource table during a break.

At center of photo (below), Gene Cable from Life Safety Consultants makes a point to one of the presenters at the Twin State Seminar. Questions flowed freely through the day.

Nora Rothschild, Environmental Technology Manager at Environmental Group discusses ASHRAE 188.

Chatting during a break are (left to right) John Crowley, Ralph Pelosi, and NEHES President, Gary Valcourt.
Routine Maintenance and Operational Testing of Emergency and Standby Power Systems
Tom Gallo—Milton CAT

Gallo prefaced his remarks saying that his reference material for the presentation is taken from the publication, NFPA 110 (National Fire Protection Association) Standard for Emergency and Standby Power Systems.

Two levels of backup power systems are recognized; Level 1 and Level 2. Level 1 systems are installed when failure of equipment could result in loss of human life or serious injury. Level 2 is less critical to human life and safety.

Examples of Level 1 include life safety illumination, fire detection and alarms, elevators, fire pumps, public safety communications, processes where power loss could cause serious life safety or health hazards and essential ventilation and smoke removal.

Examples of Level 2 are heating and refrigeration, communication system, ventilation, sewage disposal, lighting, and industrial processes.

Gallo’s presentation included an overview of requirements for testing procedures, special tools, maintenance, battery maintenance, fuel testing and other important issues.

A copy of NFPA 110 was given to each Active Member.

For full presentation: Go to the NEHES website. Standby Power Systems

Healthcare Security
Jack Conry, Director of Security, Fletcher Allen Health Care

Conry reminded the group about key elements required by The Joint Commission for Environment of Care. They include:
- Safety and Security
- Hazardous Materials
- Medical Equipment
- Fire Safety
- Utilities

He reminded attendees about a few other requirements:
- Other Physical Environment Requirements
- Staff Competency
- Monitor and Improve

Conry emphasized the need for detailed plans for security, the need for committees to monitor and evaluate efforts, the need to develop measures of success and the need to report incidents and track their resolution.

Through photos and video, Conry showed examples of ways to minimize risk and target hardening in healthcare facilities.

“Evaluate your areas for potential risks that might include violence, patient elopement, or patient injury,” said Conry. “For security issues, get the bad guy to go somewhere else!”

For a commentary on the presentation, see the President’s Message from Gary Valcourt on Page 4.

For complete presentation: Go to the NEHES website. Security

National and State Air Quality Standards Affecting Your Boilers and Generators
Cathy Beahm, Technical Assistance Specialist, NH Department of Environmental Services

The Overview of Beahm’s presentation included the following areas:
- Air Emission Basics - Hospitals
- Boiler Regulations
- Emergency Generator Regulations
- Main Take Away Points

For the complete presentation: Go to the NEHES website. Air Quality

Environmental Group

Rothschild started out with an overview of what Legionnaire’s disease is:

Legionnaires’ disease is a type of pneumonia (lung infection) caused by a type of bacteria called Legionella.

Each year, between 8000 and 18,000 people are hospitalized with the disease. Legionella bacteria are found naturally in the environment, usually in warm water.

Sources for Legionnaires’ disease include cooling towers, humidifiers, showerheads, faucets, water fountains, whirlpool baths or spas, hot springs, decorative fountains, misting machines at grocery stores, dental lines and ice machines.

Top three conditions in Legionnaires Outbreaks:
- Lack of familiarity with water systems
- Lack of effective microbiological control
- Lack of coordinated prevention efforts

For complete presentation: Go to NEHES website. Legionnaires

ASHE Advocacy
Tyson Moulton, Director of Facilities
Gifford Medical Center (VT)

See a summary of Moulton’s presentation on Page 5. For complete presentation: Go to NEHES website. ASHE Advocacy

Steve Cutter and Jona Roberts
Dartmouth-Hitchcock

Dan Burnell and Tim O’Meara, - Northeast Mechanical

For detailed info on the new CNG Facility and Boiler Conversion: Go to NEHES website. Boiler Conversion
President’s Message

By Gary Valcourt, CHFM, CHSP
Senior Director of Facilities Capital Planning and Management
2013 NEHES President

We all attend educational sessions to keep updated in our profession. At one time or another you wondered when you might be able to put the new information into practice. I’m here to say that the occasion might happen quicker than you think.

I recently attended the Twin State Seminar in Lebanon, New Hampshire, an event that is offered free of charge to membership thanks to support from the New England Healthcare Engineers’ Society.

One of the sessions featured Jack Conry, Director of Security, Safety and Parking at Fletcher Allen Healthcare centered in Burlington, Vermont with three main campuses. With a security force of 45 FTEs, Conry has his hands full offering security to a large campus.

His session gave practical tips on “best practices” for security in healthcare settings. The information was helpful and his presentation made it clear that “everyone” is responsible for security and safety.

Conry then gave his predictions on future issues facing us.

He said that we should prepare for issues surrounding workplace violence that might include mental health patients on medical floors, cases of dementia, and the prevalence of drugs and alcohol.

He went on to note issues regarding patient restraint, emphasis on lockdown and controlled access and patient elopement from a facility.

And his strongest message was our challenge to work with CMS (Centers for Medicaid and Medicare Services) to balance our regulatory compliance between patient rights versus public safety. The subject hit home since my facility is presently expecting a CMS review.

No sooner than the presentation had ended, I received a call from my office. “There’s been a patient elopement.”

Wait a minute. Wasn’t Jack just talking about this?

“Is this fate or coincidence,” I thought. “Could Jack’s predictions for the future be happening right now at my medical center?”

Let us not be fooled to think that what we might learn today will only be useful sometime in the future. Like that call I received while at the Twin State Seminar, our future concerns and issues might just happen sooner; like today.

Many thanks to our host at Dartmouth-Hitchcock and the seminar committee.

Fall Conference

On the subject of education, I encourage all of you to attend the Fall Conference in Portland, Maine this year. The registration fee is only $100 for NEHES Active, Associate, Educator/Student and Honorary Members. (If you can not afford to attend, please contact the Administrative Director’s office and we will help.) Don’t pass up the chance to network with colleagues, learn vital information and be part of the success we enjoy at NEHES.

President-Elect’s Message

By Ed Lydon, SASHE, CHFM
Assistant Vice President of Support Services
2013 NEHES Board President-Elect

Wow, what a summer for the NEHES membership! I had the great honor to represent NEHES at the 2013 ASHE 50th Annual Conference in Atlanta, Georgia in August. We started the conference with the annual Chapter Leadership Forum which was attended by me and fellow NEHES Board members, Paul Cantrell, and Jona Roberts. It was a great opportunity to meet with chapter leaders across the country. No doubt NEHES is one of the top leaders in managing a stellar program for our members in New England which was recognized with our receiving the “Platinum Level Award”.

This year was exceptional for NEHES as we have four members in the national spotlight: Dave Dagenais, Jack Gosselin, Jona Roberts and Edward Browne.

Dave Dagenais is in the running for the office of President of ASHE. Dave’s platform as to why he should be elected to the position was well thought out, convincing, and gave solid direction for the future of ASHE. Having served under Dave as a board member during his NEHES presidency and observing his dedication to the healthcare industry, ensured my confidence he should be the next ASHE president.

Similar, although in a unique track of success, is Jack Gosselin who has tossed his name in the hat for a Director position to the ASHE Board as a Supporting Member. Jack has years of experience in the healthcare industry and has established himself nationally.

Seeing these two gentlemen in the spotlight caused me to reflect back as many ASHE members did at this 50th year of the ASHE Annual conference in recognition of two NEHES members, Robert Loranger, PE,CHFM (1999), Tufts Medical Center, Boston, Massachusetts and Robert Falaguerra, FASHE, CHFM (1987), St. Francis Hospital Medical Center, Hartford, Connecticut who both served as President of ASHE and added to the great legacy of ASHE success.

Another proud moment in the national spotlight was when our own NEHES members, Edward Browne and Jona Roberts received their SASHE designation. Congratulations to both of you. You do New England proud.

Lastly, it was great to host the NEHES annual national conference dinner at the Sweet Georgia’s Juke Joint restaurant and also to see so many of the New England states represented at the Region I annual breakfast. Here, I had an opportunity to visit with many members who are heavily invested in the success of the healthcare industry.

The conference was complete with exceptional educational opportunities as well as time to network with members from throughout the country.
ASHE Advocacy Highway Runs Through New England

Moulton Works to Repave Advocacy Highway

Tyson Moulton
Director of Facilities
Gifford Medical Center
Randolph, Vermont
NEHES Board Member—ASHE Advocacy Liaison

“I’m here to help ‘repave’ the ASHE Advocacy Highway,” said Tyson Moulton, at the recent Twin State Seminar in Lebanon, New Hampshire. “I’m the NEHES liaison to help promote ASHE’s Advocacy goals.”

According to the ASHE website, the Advocacy Highway is ASHE’s response to a proliferation of healthcare regulations that may have confusing and contradictory provisions, which sometimes lead to confusing and contradictory interpretations and implementation in healthcare facilities.

“The Advocacy Highway is a two-way communications network between ASHE staff and ASHE members, ASHE Advocacy liaisons, and other health professionals with regulatory issues,” said Moulton. “I’m here to help NEHES members navigate that highway.”

The ASHE website continues by saying that the exchange of vital information is essential to ensure that existing and proposed health care regulations are arrived at through a consensus of all interested parties, and that these regulations achieve the desired objective of effectively providing safe facilities without overburdening facilities with costly regulations that do not provide added levels of safety.

The Advocacy Highway should be used to alert ASHE to locally promulgated regulations or regulatory interpretations. (ASHE Advocacy Highway) Simply submit info about code interpretations that are affecting healthcare facilities in your area, advocacy work being done in your chapters, the results of chapter straw polls on advocacy issues, and any other regulatory information you want to tell to ASHE. If a submission requires immediate attention, please note that in your submission so that ASHE staff can understand the timeline for action on the issue.

“The goal is to answer member questions usually within 24 to 36 hours,” explained Moulton.

Noting that the Advocacy Highway is a two way street, ASHE sends notice of new or impending regulations or their interpretations to ASHE members and the advocacy liaisons from each ASHE Chapter, who can distribute the information to their chapter members. In addition, ASHE will use this information in national code reform initiatives as validation of contradictory and/or confusing regulations.

“My goal is to share information that appears on the Advocacy Highway on a regular basis to NEHES members,” said Moulton. “If members ever have questions or concerns, they should contact me immediately to help get you a timely answer. Moulton can be reached at tmoulton@giffordmed.org or 802-728-2240.

NEHES Scores Platinum Once Again

IT IS OFFICIAL!

NEHES has earned the Platinum Level of Affiliation, the highest designation that can be attained by an ASHE Chapter. The award was officially presented at the recent ASHE Annual Conference this summer in Atlanta, Georgia.

“This achievement really demonstrates the NEHES Board of Directors’ hard work and commitment to our members, especially in the areas of education, advocacy, and communication,” said Gary Valcourt, NEHES President.

“The strategic plan and focus over the past year required lots of effort and the work has paid off. Our chapter continues to be recognized for its leadership as one of the strongest in the country,” added Valcourt. “I congratulate each of our members who share in this great honor.”

THE NEW ENGLAND HEALTHCARE ENGINEERS’ SOCIETY
2012 PLATINUM LEVEL AFFILIATION
AMERICAN SOCIETY FOR HEALTHCARE ENGINEERING
George Player  Eric Goralnick, MD

On Patriot’s Day, Monday, April 15, 2013, thousands of runners from all over the world converged on the City of Boston to participate in the annual Boston Marathon. Little did they know that two homemade bombs had been planted near the finish line, resulting in the deaths of three, and harming 264 individuals—some with traumatic amputations. The Brigham and Women’s Hospital Emergency Room was suddenly inundated with trauma patients who had survived this horrific event.

Attendees at the NEHES Fall Conference will learn first hand of the experience through two key players that were significantly involved with the care and treatment of those injured.

Presenters will include George Player, CPE, FMA, Director of Engineering Services at Brigham and Women’s Hospital and Dr. Eric Goralnick, Medical Director of Emergency Preparedness and Associate Clinical Director, Brigham and Women’s Hospital, Emergency Department.

According to an article from USA Today, Goralnick had been at the Prudential Center, about a block away from the marathon, when he learned about the bombing. When he got to his hospital, things were already in motion. Thirty-one people were treated.

"It was an amazing sight to see all these providers—nurses, physicians, technicians working at the speed of light," he said. "There's not a lot of processing in the moment."

In a National Public Radio interview, Goralnick said, “You know, we train for this. This is obviously a very catastrophic event, but it's an amazing thing despite all of the chaos to see our teams come together throughout the Boston medical community and support each other.”

And as cited in the New England Journal of Medicine in an article by Goralnick and Jonathan Gates, MD, “As we say in the U.S. Navy, 'We train like we fight, and we fight like we train.' In Boston, we do the same. In these extraordinary circumstances, successful care came from colleagues working alongside familiar teammates, performing familiar tasks. When challenged, each team performed as if the situation were routine. In Boston, we fight like we train."

In the same article, Goralnick and Gates reflected on the experience and its aftermath.

“We have learned so much, but we have so much to learn.”

Don't miss this opening address at the NEHES Fall Conference!

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Edward M. Browne  Jona Roberts

SASHE Honors Two in New England

Two members of NEHES have been honored this year by achieving Senior status (SASHE) from ASHE.

The two awardees are Edward M. Browne, FASHE, CHFM, SASHE, the Corporate Director of Facilities, Real Estate, and Construction Management at Cape Cod Healthcare in Hyannis, Massachusetts and Jona Roberts, CHFM, SASHE, Engineering Manager at Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire.

SASHE is granted to an ASHE active member demonstrating a commitment to the healthcare facilities management profession and recognizes their contribution to the industry through leadership, education and publishing.

ASHE Levels of Recognition

For more information, see the ASHE Awards.

Crystal Eagle Award

This distinguished award recognizes one outstanding ASHE member for his or her excellent leadership qualities, innovation, and overall contribution to ASHE and/or the field of healthcare engineering and facility management.

Emerging Regional Leader

One person from each ASHE region, is honored for their exemplary leadership skills and their commitment to the field of healthcare facility management through their local and/or national involvement with ASHE.

Excellence in Facility Management Award

Honors individuals and teams who exemplify how facility managers and caregivers join together to identify an issue and create a proactive and viable approach to attaining resolution that optimizes the physical environment and improves patient care.

Vista Awards

Recognizing teamwork in the design and construction of the healthcare physical environment for new construction, renovation and infrastructure.

SASHE

Senior status (SASHE) is granted to an ASHE active member demonstrating a commitment to the healthcare facilities management profession and recognizes their contribution to the industry through leadership, education and publishing.

FASHE

Fellow status (FASHE) is granted to ASHE active members who have achieved Senior status and continue to demonstrate commitment to the healthcare facilities management profession.

Certifications

In an effort to develop leaders who work in unison to optimize the physical healthcare environment, ASHE offers two professional certifications: Certified Healthcare Constructor (CHC) and Certified Healthcare Facility Manager (CHFM).
Education is vital in today’s healthcare facility profession. As the complexity of what we do changes with technology and compliance regulation, today’s healthcare engineer has to expand their scope of knowledge just to keep up with the day-to-day requirements of our jobs.

A recent communication from Dale Woodin FASHE, CHFM, Senior Executive Director with the American Society for Healthcare Engineering informs NEHES about some developments in the pursuit of education.

Woodin explains that ASHE has developed relationships with a number of universities to offer degree programs. They include Purdue University, Brigham Young University, Southeast Missouri State, Texas A&M University, Arkansas State University, and Arizona State University.

The one common thread with all of these programs is that no one offers a degree specific to healthcare facility management or healthcare construction. They offer a course or two focused on healthcare creating an emphasis in healthcare but the degree is in a traditional field such as facility and property management or construction management (or architecture).

This year, ASHE formed a relationship with Owensboro Community and Technical College in Owensboro, Kentucky due to their development of an associate degree specific to healthcare facilities leadership.

The program is available entirely online and in-state tuition is charged regardless of where the student resides. The convenience of online study will allow access to the program from anywhere throughout the country.

Owensboro has relationships with four year colleges to allow students to get full credit for this work if they go further to achieve a four year degree.

ASHE is looking forward to full program implementation in January 2014.

About the Owensboro Community and Technical College Program

The Healthcare Facilities Leadership (HCFL) Associate Degree in Applied Science program is designed to prepare students for careers in the unique field of Healthcare Facility Management.

The curriculum provides students with foundational knowledge in the areas of Leadership, Management, Finance, Infection Control, Compliance Codes and Standards, Planning Design and Construction, and Maintenance and Operations.

The program is designed for those currently employed in the healthcare facilities field wishing to enhance their skills in preparation for possible advancement; as well as, those looking for entry level positions in the healthcare facilities field.

Under guidance of program faculty, students will gain experiential knowledge through end of program capstone courses.

Program Features:

- The entire curriculum is delivered online providing flexibility and broad coverage.
- Online delivery of courses allows out of state students to pay in state tuition prices.
- The program is designed for incumbent workers in the Healthcare Facilities field, but will also accommodate students looking for entry level healthcare facilities positions.
- The program curriculum was developed in collaboration and partnership with ASHE and the Kentucky Society of Healthcare Engineers.
- The program was conceived to help fill the growing employment gap for retiring Healthcare Facilities Managers.
- Curriculum is designed around the five content areas of the AHA Certified Healthcare Facilities Management (CHFM) exam preparing students for the CHFM exam after they have completed the required years of work experience to take the CHFM exam.
- The program is supported by ASHE and the KSHE Boards of Directors.
- The program is designed to accommodate transfer to baccalaureate Healthcare Facilities Management programs.
- Program implementation is scheduled for January, 2014 pending curriculum and program approval.

For information or to apply for the program, contact Admissions Navigator, Tracy McQueen at 270-686-4443 or tracy.mcqueen@kctcs.edu.
Saluting New England’s Certified Healthcare Facility Managers

CHFM Program

John R. Gosselin
Robert W. Hall
Ronald S. Hussey
Steven A. Jalowiec
Brian L. Johnson
Kerry William Kerr
Thomas P. Lazzaro
Frederick A. Leffingwell
Rodrick J. Neff
Paul Bernard Strycharz
Allen Mark Croteau
John Joseph Crowley
Paul Deviller
John A. D’Onofrio
John P. Duraes
Joshua B. Farber
Justin C. Ferbert
Scott A. Johnson
Kevin J. Keating
Thomas Lake
Michael Stanley Laroche
Christopher G. Leblanc
John G. Lombardi
Edmund L. Lydon
William J. Martin
Ryan R. Moore
Jonathan R. Nelson
George Nolan
Mus G. Pam
Ralph T. Pelosi
Joshua K. Philbrook
Edward Pitts
Mark Racicot
Harry Roberge
Mark E. Robinson
David A. Rosinski
Geoffrey Slownan
Gary A. Valcourt
Larry J. Williams

Maine

Maine Healthcare Engineers’ Society

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Robert J. Falaguerra

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David N. Fontes
James D. Gilmore
Michael E. Haire
Richard J. Munson
Ronald Paul Vachon
John Romolo Zoglio

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State Chapter Organizations

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Alternate: open

Maine Healthcare Engineers’ Society

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Alternate: William Smith
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Rhode Island Healthcare Engineers’ Society—Chapter Representative: open

Vermont Healthcare Engineers’ Society

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For info on CHFM, contact jona.roberts@hitchcock.org
Remote Monitoring Measures: The Impact of Construction

Sharing with NEHES Members

By Jeffrey A. Zapfe, Ph.D.
President of Acentech, Inc.

Until recently, vibration sensitive equipment like MRIs and electron microscopes were typically located on grade-supported slabs, often in the hospital’s basement. This type of equipment has been migrating upward, closer to patients, where it is on more flexible floors that are more prone to vibrations which may interfere with the equipment’s efficient operation.

The suppliers of sensitive equipment generally specify specific limits on the vibrations of the floor on which the equipment is to be located.

Unfortunately, the exact equipment items to be placed in a facility are often not known early in the facility’s design process. Because of this, a set of generic vibration criteria (shown, for example, in AISC Design Guide 11 “Floor Vibrations Due To Human Activity”) has been developed to allow designers to classify the vibration sensitivity of a building’s areas and thereby to enable the design of suitable structures.

These generic criteria are given in terms of “VC curves” that indicate limits on the floor vibration velocity. The 2010 Guidelines for Design and Construction of Health Care Facilities, published by the American Society for Healthcare Engineering, recommends that vibrations of floors in patient rooms/areas, ORs and treatment rooms be limited to 4,000 micro-inches per second (\( \text{min/s} \), colloquially called “mips”) and that floors in administrative and public circulation areas be limited to 8,000 mips. To provide some perspective, the threshold of perception of the most sensitive humans corresponds to 4,000 mips. Sensitive areas have limit below this perception threshold: for example, 2,000 mips is often specified for laboratory and animal research areas and limits as low as 500 mips are representative of MRI spaces. The key to a successful design is to identify the vibration sensitive areas in the building and to provide the structure necessary for obtaining appropriate vibration environments.

One aspect of new construction that should not be overlooked is the potentially adverse effect of construction-related vibration on nearby facilities, particularly those that contain sensitive equipment or operations.

For example, the construction of a new 245,000 square foot, nine-story Ambulatory Care Center next to an existing hospital at Boston Medical Center raised concerns about interference of construction-related vibrations with ongoing hospital activities. Particularly severe vibrations are known to result from demolition, soil excavation, and pile driving. In situations like these, pre-construction testing with representative equipment is the best way to quantify the expected impact of construction activities. The results can be used to determine which areas may or may not be affected during construction and to develop mitigation strategies. These may involve scheduling, selection of construction methods and equipment, providing sensitive items with supplemental vibration isolation, and real-time monitoring of vibrations in critical areas.

In the aforementioned Boston Medical Center project, and in a similar project at the New England Baptist Hospital, vibration measurements were carried out in sensitive areas of the hospital before and during a series of representative construction activities. The measured vibrations were compared to criteria for MRIs, CT scanners, and operating rooms, in order to evaluate the potential impacts. At Boston Medical Center, real-time vibration monitoring of the vibrations in the sensitive areas was then used continuously during the actual construction, with automatic alarms sent to project and hospital personnel if any pre-set vibration limits were exceeded. This allowed the hospital and construction personnel to anticipate complaints from staff and to mitigate the construction activity, if necessary.

At New England Baptist Hospital, the tests and data were used to educate the hospital staff and to devise strategies that permitted the hospital to continue carrying out its work during construction without continuous monitoring.

Remote monitoring, where measurement systems are installed in critical areas and their data are observed at other convenient locations, has been found to be especially useful not only for coping with construction, but also for evaluating the suitability of sites being considered for sensitive activities. As an example of the latter, remote monitoring is being used at the University of Connecticut Health Center to determine whether a selected location on a higher floor is suitable for relocation of its Center for Advanced Reproductive Services.

In cases such as the ones illustrated here, remote monitoring can be a cost-efficient tool in view of its capability to provide data and alarms in real-time and thus to protect hospital environments from undue vibrations – all without the need to have specialists on site for extended periods.

We welcome article submissions from all NEHES members. Submissions should be about 750 to 1000 words. If you have an idea to share, contact Dan Marois, Newsletter Editor at dmarois@fairpoint.net.
Recently, Northeast Health System affiliated with Lahey Clinic to form a new integrated healthcare system called Lahey Health System. This is the result of months of extensive planning, due diligence exploration, regulatory reviews, and seeking employee and physician buy-in, which I have had the pleasure of being a part of.

The journey to create this healthcare system began more than a year ago with a vision to have a community based healthcare delivery system that would allow us to grow and meet our mission of providing quality community care locally at the lowest cost possible to consumers. This affiliation was spurred, in large part, to meet the changes in the healthcare landscape and the onset of ObamaCare.

With these changes, the facility manager should be aware of the impact to human resources, purchasing power, and the improved healthcare technological efficiencies (electronic medical records, clinical decision support systems, etc.) on the horizon that will forever change the way we deliver healthcare services.

In our case, pulling together two very different patient care delivery models has been a great challenge, which if not executed correctly, will impede the performance of the newly formed healthcare organization.

Lahey Clinic is a physician-led, nonprofit group practice (clinic model) whereas Northeast Health System is an integrated community nonprofit healthcare system comprised of a network of community hospitals, behavioral health services, long-term care, and human service providers.

The good news is that they share a common focus on clinical excellence, quality and safety, and operational efficiency. However, to be successful, much work still needs to be done in business integration and planning.

One of the most important understandings for these affiliations and mergers is that organizations each have their own culture. It is important to recognize this early on, and to keep the process as transparent as possible with employees. Treating transformation as an event, rather than a mental, physical and emotional process, is no doubt critical for the success of combining organizations.

According to Carol Goman, Ph.D. in an article, *The Biggest Mistakes in Managing Change*, a large-scale organizational change usually triggers emotional reactions; denial, negativity, choice, tentative acceptance, commitment. This is so important for leadership to understand so that they can either facilitate this emotional process or ignore it at the peril of the transformation effort.

Another important aspect of organizational change is the new governance and hierarchy. Leadership teams in each organization will be impacted. These newly formed organizations will most often name the new hierarchy early in the process as to ensure organizational direction stays intact.

Many newly formed system positions are often filled with leaders from multiple organizations. This provides a level of relief to employees who see the mergers as “US” versus “THEM”. It is best for the new organization to announce the change in governance quickly so that they will be successful in moving change forward.

From my experience, there are four areas of focus that are needed while creating affiliations.

- Look at human resources within departments.
- Establish value based purchasing across the system.
- Develop a common identity to secure and gain market share.
- Move quickly into to becoming an accountable care organization.

For facility managers, the new organization could present new leverage with increased buying power when meeting with vendors, utilities, contractors, etc. Let’s face it, the lure of securing business from a newly formed healthcare system is highly desirable to vendors and they will be highly competitive to receive it.

The success of value based purchasing, as an example, hinges on the health system breaking down barriers to capture the quick wins in savings by combining contractual agreements for purchase services and creating common product streams.

Facility managers will become a key part of management teams creating new organizations. Their ability to be flexible and nimble in this new healthcare environment is vital. If they cannot successfully affiliate or merge into a larger system, the effort will flounder and low cost effective quality care will not come to fruition. Facility managers will need to be strong leaders for these new organizations.

Another important strategy is to ensure that the right human capital (clinical providers, facility staff, etc.) is in the right locations creating capabilities to capture the market change quickly and successfully. If you do the right things, you get the right alignment and meet objectives. “People start to learn how to work across the geographic functional boundaries” according to Bill Leonard in his Incentives & Recognition article, *Gutting out Costs at GM*.

What this means to the facility manager is to be insightful and understand where assets (property, facilities, technology, etc.) should be developed or changed in the various geographic areas. Facility managers will need to be a part of and participate in the new vision.

A strategic human resource approach is a must with a shift from people-centered values of human resources to harder business value approach which is necessary to deliver on corporate strategies.

According to Rana Sinha, *What Is Strategic Human Resource Management? Ezine Articles*, “Strategic Human Resource management can be defined as the linking of human resources with strategic goals and objectives in order to improve business performance and develop organizational culture that foster innovation, flexibility and competitive advantage in an organization.”

Facility managers will need to become involved as a partner in planning and implementing new integrated health systems. They may need to adjust the facilities’ delivery of services and ensure that strategies are in place to recruit, select, train and align personnel appropriately across the system to meet the new service demands.

(Continued on Page 11)
Additionally, facility managers need to be seen as positive and effective change managers within the ranks of the transforming organization. 

(Change management has evolved over time and one of the successful models that I have used is the ADKAR model. This model has five specific stages that must be realized in order to be successful in making change. For more info about [Go To ADKAR])

Healthcare is rapidly changing with the move from fee for service to the advent of global payment systems, accountable care organizations, value based purchasing, pay for performance, the emphasis on at risk contracts with payers, and the need to cut waste from the day to day delivery process. These changes demand the need for an efficient, culturally bonded, and talented facilities work force.

Healthcare has always relied heavily on strong facility managers to develop and support physical spaces that meet the needs of service delivery. Today’s environments must support a wide continuum of care that delivers safe, efficient and high quality services at the lowest cost to consumers. The facility manager does all this while conforming to the most stringent of regulations and guidelines in any industry. No small challenge.

As these large integrated healthcare systems form to meet the needs of the new healthcare delivery mandates, it must be understood that complexity will need to be met with a workforce that has the ability to be agile, embrace change, develop new competencies, and be creative.

Facility managers need to prepare themselves for this new paradigm shift. It is so important to recognize today that we live, work, and compete in an increasingly competitive healthcare environment which demands the ability to be lean, efficient, and flexible.

My prediction is that the new healthcare market will deliver more care locally in homes, clinics, or outpatient facilities and that hospitals, in the traditional sense, will become far less central to the healthcare delivery process.

With this in mind, facility managers need to move quickly to be a part of the change ahead. If not, they risk being left behind.

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**In Memoriam—NEHES Friend, Fred Rohde 1956-2013**

A special colleague left us with the passing of Frederick John Rohde VI on Monday, July 1, 2013, at his home. Brian Sallisky, Vice President of the Vermont Healthcare Engineers’ Society from Southwestern Vermont Health Care spoke highly of Fred.

“For those who were blessed to have met and spent any time with Fred, you know what a fine and gentle man he was. When you first met Fred, you were impressed by his obvious presence and the stern expression that had such little effect in concealing the gentle and human spirit that so defined him. Fred was always there when called upon be it to offer advice amassed by his years of experience and observation, or to offer some personal advice or comfort when your day seemed just too much to handle alone.”

Fred had been a long time member of VHES, NEHES and ASHE. As Immediate Past President of VHES and as a long time member, Fred’s contributions can be long remembered as the driving force that pulled off an impressive NEHES Annual Conference in the hurricane ravaged mountains of Vermont just two short years ago.

“Fred had been where we have all often found ourselves.......at the end of that same rope with no escape in sight. Fred had spent the last several years of his life struggling with a variety of ailments and illnesses. Through it all, Fred kept that same sense of fairness and goodwill. Fred was and will always be remembered by me as a true and loyal friend; a person of integrity whose values and uncompromising sense of right and wrong are not now, nor can ever be subject to debate.”

In sharing the news of his passing, Fred’s daughter, Chelsey, said that her father was “very proud” to be a member of both VHES and NEHES.

NEHES Board Member, Ron Vachon fondly remembers Fred’s comments at the last board meeting that he attended at the spring conference in Leominster, MA.

“We are very fortunate to enjoy success as a Society, and where I am at in life, I reflect on what is important. It is important to make a difference and we should use our resources always with a focus to do what is important in change to better people’s lives,” said Fred.

“These words still resonate with me,” said Vachon.

“Everyone who knew Fred will remember him as always willing to take the time to help anyone,” said Gary Valcourt, NEHES President. “He will be missed.”

View Fred Rohde’s obituary.
National Healthcare Engineers Week—October 20–26

A Chance to Recognize Your Profession

National Healthcare Facilities and Engineering Week happens only once a year. Take advantage of the time to recognize your profession in your facility and in your community.

Take time during National Healthcare Facilities and Engineering Week to recognize yourself and the members of your team for all they do every day to optimize the healthcare physical environment.

Here are a few ways to get the ball rolling.

- Involve your marketing and public relations department to promote National Health Care Facilities and Engineering Week both in the facility and in your local community.
- Sample press releases are available on the ASHE website that you can adapt for your local media outlets.
- Hold an open house in your areas. Invite staff for a tour of your department. Have members of your team create an album of pictures that show the work that they are involved in on a daily basis.
- Give a behind the scenes tour in areas that are not often seen by most staff members. They will be interested to know how you keep their facility running smoothly.
- Conduct a trivia contest in your hospital newsletter or on your Intranet website. Ask questions that will get staff thinking.
- What areas are covered by your emergency power generators?
- Place posters throughout your facility that highlight the week.
- Provide staff with National Healthcare Facilities and Engineering Week and/or ASHE logo items to wear during the entire week. This is a perk for your staff and it increases their recognition as members of an important team.
- Recognize your team with a special breakfast or luncheon. Show that you want to take the time to celebrate their contributions to your organization.
- Ask your CEO to attend a staff meeting with your team to thank them for their fine work in facilities and engineering. Remember that a “pat on the back” can reap great rewards.
- Work with your state chapters to have National Health Care Facilities & Engineering Week proclaimed by the Governor and Legislature.

For more ideas, go to the ASHE Recognition page.

Member to Member — Making A Difference for Visitors

The recent Twin State Seminar was held at the Dartmouth-Hitchcock Medical Center in Lebanon, NH. It has a 225 acre campus that is home to 7000 employees. It is the biggest and newest hospital I’ve ever seen in my 25+ years working in healthcare.

Jona Roberts, the Engineering Manager at the facility hosted the event. Here are my experiences as I made my way on the Lebanon, NH campus.

The parking lot attendant was well informed about the healthcare engineers that were coming onto the campus. When I told him why I was there, he immediately knew about the event and he directed me to an offsite parking lot where I would take a shuttle bus back to the medical campus. It made sense. Parking lots nearer to the hospital should be reserved for patients.

When I boarded the shuttle bus, I told the driver my destination for the meeting. He told me that he had no idea where anything was on the campus. (I learned that bus drivers are not hospital employees.) However, he did drop me off at the front entrance and said that someone at the front desk could help. The information desk person knew about the meeting and mentioned that there were “quite a few of you folks” already here. She gave me directions to take the nearest elevator, told me to go up one level and proceed down a long hallway where I would see another information desk that could help me.

Got to the information desk and asked for guidance. An employee, standing nearby and wearing a housekeeping uniform, offered to walk me to my destination at Auditorium E. I gladly accepted the offer. She was pleasant and helpful. However, when she left me, I realized I was at Auditorium G not E. With good signage, I was able to find my way from there to the meeting room. Mission accomplished.

The best part of the visit was that everyone had a smile and a welcoming manner from the reception desk staff, to clinical staff walking the hallways, to food service staff. Their willingness to help, if they could, or to direct me to someone who could help, was exemplary.

Jona Roberts gave us a good reminder. If you have visitors coming to your facility, a bit of advanced preparation with key departments or individuals can make a world of difference to insure a positive experience.
NEHES 2013 Proposed Bylaw Changes

At the NEHES Annual Meeting during the Fall Conference, members will be asked to vote on two proposed bylaw amendments that have been endorsed with ten signatures of Active or Honorary Members. Here is a primer on the bylaw changes. Thanks to NEHES members, John Crowley and Ed Lydon who have agreed to share their opposing views on the subject.

Amendment #1 - Article IV Section 4-4
What will change: The word “directly” would be removed from this section.
If passed: Active membership would be open to engineers who are not directly working for a healthcare organization.
If not passed: Active membership will remain available only to engineers who are directly employed by a healthcare organization.

Amendment #2 - Article IV Section 4-4
What will change: This bylaw amendment would create a new membership category by adding “Active Member Non Directly Employed.” The word “directly” would be removed from this section. This member would only serve on committees and not vote or hold office.
If passed: A new membership category would be created: Active Member Non Directly Employed.
If not passed: A new membership category will not be created.

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<td><strong>Section 4-4: Active Membership:</strong></td>
<td><strong>Section 4-4 A: Active Membership Non Directly Employed:</strong></td>
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<td>Active Membership in the Society shall be available to those individuals who are directly employed in or by healthcare-related facilities (those that provide patient care), and who have direct responsibility in healthcare facility operations (e.g., facilities management, plant engineering, planning/design/construction, security, safety, clinical engineering, environmental services, telecommunications, and emergency management). Active Members may vote, hold office, and serve on committees. At the discretion of the Board of Directors, any Active Member whose circumstances change so that they no longer meet the criterion for active membership may be allowed to continue their membership status for the remainder of the current dues period and/or term of office.</td>
<td>Active Membership Non Directly Employed in the Society shall be available to those individuals who are directly employed in or by healthcare-related facilities (those that provide patient care), and who have direct responsibility in healthcare facility operations (e.g., facilities management, plant engineering, planning/design/construction, security, safety, clinical engineering, environmental services, telecommunications, and emergency management). Active members Non Directly Employed may vote, hold office, and serve on committees. At the discretion of the Board of Directors, any Active Member Non Directly Employed whose circumstances change so that they no longer meet the criterion for active membership may be allowed to continue their membership status for the remainder of the current dues period and/or term of office.</td>
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Sound Off on Proposed By Law Changes

**By Ed Lydon, SASHE, CHFM**

I support the move to allow Active Membership to engineers who are not directly working for a healthcare organization.

NEHES is a much different organization than it was when founded 55 years ago. At that time, the Active Membership category made sense. Engineers were employed "directly" by healthcare facilities; that was the norm.

Today’s environment is ever changing in the scope of the healthcare engineers profession. In recent decades, it is commonplace for engineers to work for contract management organizations hired by healthcare facilities to run their operations. Why should we deny that person Active Membership in our Society simply because they don’t work “directly” for a healthcare organization. In fact, in today’s world, those of us who are directly employed by an organization could easily find ourselves in a contract management position overnight.

I urge you to give careful consideration to the bylaw changes.

**By John Crowley, SASHE, CHFM**

I do not support the move to allow extending Active Membership to engineers, sales representatives, or others who are not directly employed by a healthcare organization.

I ask, “Who best aligns with the needs of the core membership and core values of the healthcare engineering profession?” I believe it is the facility personnel working directly in a hospital involved with supporting patient care, and the needs of staff and visitors.

Supporting Members and their relationship with Active Members and the Society has served both us, and them, well. Supporting Members will continue to be a vital part of the Society and their contributions have played a major role in our growth.

When it comes to the needs of the Active Members, what is best lies in the system that is now in place for NEHES. We are an individual membership group and not a trade or sales organization.

I urge you to give careful consideration to the bylaw changes.
Dave Rosinski, CHFM, has been working on improving the public relations image of NEHES through a newly designed information brochure.

Dave is the Director of Engineering, Security, Biomed & Emergency Management at Noble Hospital in Westfield, Massachusetts. He took on the task realizing that the previous brochure was getting outdated and still using the old NEHES logo.

The new design makes better use of spacing out information and the look and feel is updated to reflect a more modern healthcare engineering society.

With design work from Marie Carija of MACintegral design in Mystic, Connecticut, the newly revised brochure will be fully introduced at the Fall Conference in Portland, Maine.

Highlights of the new brochure include:

- **Who we are**
- **Use of new logo**
- **Recognition of individual states**
- **Generic message from the Board will increase the shelf life of the publication.**
- **Benefits of membership**
NEHES News Nuggets

**Spring Conference Set for Leominster, MA in 2014**

NEHES member, Mark Blanchard will be heading up the day long spring conference in 2014 slated for Leominster, Mass. (The date is to be announced.) “I just had our first conference call to start planning the event,” said Blanchard. “I’m working on the educational piece as we speak,” added Blanchard responding to a recent e-mail. Mark is President of the Vermont Healthcare Engineers Society.

**Architecture for Health Showcase**

To assist healthcare leaders in the planning, design, and construction process, the American Society for Healthcare Engineering (ASHE) has developed the Architecture for Health Showcase. This program provides information on the latest projects in healthcare facility design and construction, including descriptions, images and architect information. While the showcase has an onsite gallery at major conferences, it does have a printed compendium and an online gallery.

The Architecture for Health Showcase features innovative projects and inspired designs from around the world, along with information that can help guide the decision-making process for your hospital’s next project. Go to Showcase for more info and to see the online gallery.

Baystate Medical Center’s new 72,000 sq. ft. Emergency & Trauma Center in Springfield, Massachusetts is one of the facilities featured in the Architecture for Health Showcase.

**Other Proposed Bylaw Changes**

In addition to the item on Page 13, there are two other Proposed Bylaw Changes for the Annual Meeting.

**ARTICLE IV Eligibility and Membership**

Section 4-3: Modify to reflect that there are more than 4 types of membership.

**Existing Section 4-3:** There shall be four (4) types of membership: Active, Associate, Honorary and Supporting. Only Active and Honorary Members are eligible to vote.

**New Section 4-3:** The following are categories of membership: Active, Associate, Honorary, Supporting and Educator/Student Membership. Only Active and Honorary Members are eligible to vote.

**ARTICLE V - Officers**

Section 5-16: Delete entire section. The Executive Secretary position no longer exists.

**NEHES On Target With Board Goals**

According to NEHES President, Gary Valcourt, every year, the NEHES Board of Directors meet at a retreat to review the work of the Society to see if goals were met for the year. They also take the opportunity to chart new goals for the coming year.

This year’s retreat will be held on November 8 & 9. If any of you have any goals, projects or initiatives that you’d like to see in 2014, please drop a note to President-Elect, Ed Lydon. At the June NEHES Board Meeting, Gary announced that this year’s goals are about 80% complete with more work to be done before the end of this year.

“As an all volunteer run Board of Directors, with members who have busy work schedules, I appreciate all the hard work done by the Board to keep our organization strong. Your hard work pays off by maintaining a first class professional organization,” said Valcourt.

**Keep Memberclicks Clicking**

Josh Philbrook, Membership Chair for the Society, sends a reminder to keep those membership renewals coming by using the new online tracking system. Memberclicks Renewal
**NEHES—Who We Are**

The New England Healthcare Engineers’ Society (NEHES), founded in 1958, is a professional Society for individuals responsible for the Environment of Care in the delivery of patient care. The Society is affiliated with the American Society for Healthcare Engineering (ASHE) and consists of several chapters throughout all six New England states.

The Society’s goals are:

- To promote better patient care by taking advantage of the latest developments in healthcare facility management, design, operation and maintenance techniques.
- To promote mutual exchanges of technical assistance, ideas, and experience among members and other healthcare engineering professionals.
- To promote the professional engineers through continuing education.

**GOOD READS for NEHES Members**

(Good Reads is provided as a service to NEHES members and does not constitute an endorsement by NEHES. These are sources that members have found helpful in their work.)

NEHES President Elect, Ed Lydon recommends:

*The Heart of Change: Real-Life Stories of How People Change Their Organizations*  
by John P. Kotter (Author), Dan S. Cohen (Author)

“My favorite book and this author is a well known expert”

See YouTube Videos by John P. Kotter
Top Joint Commission Citations—Key Areas of Concern

Edited from an article by Deanna Martin, senior communications specialist for the American Society for Healthcare Engineering

In the past few years, seven out of 10 top citations from Joint Commission surveys have stemmed from problems in the healthcare physical environment.

George Mills, MBA, FASHE, CEM, CHFM, director of the Department of Engineering at The Joint Commission, recently spoke about these issues at the ASHE Annual Conference, where he was one of three plenary speakers from accrediting organizations.

- **Means of Egress**
  Mills said at the Annual Conference that—not surprisingly—means of egress citations are once again near the top of the list, coming in at number two on the overall list of citations and number one of the citations related to the healthcare physical environment. Means of egress citations include corridor clutter and issues with life safety drawings.

  Facility managers are often frustrated by corridor clutter citations because it is not maintenance equipment left in corridors causing the problem but items used by clinicians, including computers on wheels and IV poles, Mills said. The key for facility managers is to seek cooperation from nurses and other equipment users, stressing the importance of keeping hallways clear.

  Evacuation exercises and drills can help show clinicians why this is so important, Mills said, and making regular rounds to develop relationships with these equipment users is critical to lasting success.

  "If you’re satisfied sitting down in your office working with your contractors and your staff and you’re not doing rounding and you’re not out and about meeting your users, then you’re never going to be successful in corridor clutter management," Mills said. "But when you start developing those relationships with users, that’s when [(you’re) going to be successful and get [your] corridors clear and clutter free."

- **Fire Barrier**
  Citations are plentiful regarding fire barrier penetrations, fire door issues, and duct issues. "Almost half the time we surveyed, we found problems with our barriers," Mills said.

  The Joint Commission and ASHE are working with the fire-stop industry and others to use symposiums to educate facility staff about barrier management. "Because this has been such a long-standing finding for us...we really felt like we had to do something," Mills said.

  Watch the ASHE Insider and the ASHE website for more information about upcoming barrier management symposiums.

- **Fire Safety Testing**
  This issue is often cited when facilities cannot provide documentation related to their testing. Mills said it is unacceptable to have a contractor inspect fire safety at a hospital and not provide a timely report. Instead of waiting five or six weeks for an overall report, he said, facility managers can require contractors to provide a daily punch list of anything that failed safety testing. Work orders can then be used to address those issues, providing documentation for corrected problems even before the contractor finishes a larger report.

- **Smoke Barrier Penetration**
  This problem is similar to the fire barrier problem, Mills said, and solutions will be discussed in upcoming barrier management symposiums.

- **Unsafe patient care conditions, including unsecured oxygen cylinders and ventilation, temperature, and humidity issues.**
  Mills said facilities can determine how often they monitor humidity and temperature, but documentation needs to be provided. If your facility monitors daily, The Joint Commission needs to see a daily log. If your facility monitors annually, you need to provide an annual log.

- **Problems with sprinklers, including the requirement to maintain 18 inches or more of open space from below the sprinkler deflector to the top of any storage located below.**
  Just like corridor clutter, Mills said, facility employees are likely not the ones stacking items on top of shelving. This is another instance where success comes by working with the users and educating them on the issue.

- **Citations for improper system design; the inability of the mechanical system to achieve required results; the lack of written inspection, testing, and maintenance frequencies; and problems with appropriate air pressure relationships, air exchange rates, and filtration efficiencies.**
  Mills said his top concern for the future of healthcare is the aging infrastructure of our building systems. His opinion is that facility managers need to discuss these issues with their leaders and not to rely too heavily on building automation systems to ensure systems are operating properly. "We still need to be walking around doing our physical checks and making sure these things are running the way [we] think they’re running," he said.

  For full article, [Citations](#)
ASHE Talks To State Law Makers About Codes & Standards

ASHE visited the National Conference of State Legislatures Legislative Summit in August to speak to lawmakers about the need for improving the codes and standards regulating healthcare facilities. Conflicting, outdated, and unnecessary codes siphon scarce hospital resources away from priorities such as patient care. Many state lawmakers are interested in reducing healthcare costs, but aren’t sure how to do so without negatively impacting patient care. ASHE will talk to lawmakers at the Legislative Summit to show how they can help.

At the conference, ASHE will be distributing copies of the 2013 Advocacy Report, which outlines the reasons why hospitals need updated and unified codes.

The Advocacy Report is available online, and ASHE members are welcome to share it with others affected by healthcare regulations.

NFPA Agrees To Remove New Requirement on Emergency Power Receptacles

The ASHE advocacy team has been working to prevent a requirement from being added to NFPA 70: National Electric Code® that would add an indicator light to each receptacle on emergency power.

ASHE member Walt Vernon, the chair of the NFPA 99 Electrical Systems Committee, filed an appeal to the NFPA Standards Council asking to remove the requirement, which would have required an illuminated face or indicator light to indicate that there is power to non-locking type, 125-volt, and 15- and 20-ampere receptacles. After considering the appeal and hearing testimony from a team of ASHE members, the Standards Council voted to uphold the appeal and reject the proposal for indicator lights on emergency power receptacles.

ASHE Director of Codes and Standards Chad Beebe, AIA, SASHE, said the Standards Council granted the appeal because the illuminating indicator light is a performance issue under the jurisdiction of NFPA 99: Health Care Facilities Code, not an installation issue that would be covered under NFPA 70. It’s important to note that a similar proposal on indicator lights has been proposed to the NFPA 99 electrical committee in the past, Beebe said, and was denied by that committee because there wasn’t substantial technical data to prove that there is a problem that could be solved by requiring indicator lights.

Beebe said the Standards Council’s decision will save hospitals money and time. Although the cost per receptacle may only add $3 or $4, the number grows when you multiply that by thousands of receptacles and include the cost in replacement schedules.

“This is a good example of how a few ASHE members can make a difference in the codes,” Beebe said.

Life Safety Code Comparison Available

The 2012 edition of the Life Safety Code offers new design and compliance options for healthcare facilities that didn’t exist in earlier editions. Because not all jurisdictions use the same edition of the code, the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission permit the use of the 2012 edition in its entirety or on a single-element basis.

This monograph provides an exhaustive list of the changes in the new edition and a detailed comparison with the 2000 and 2009 editions to help users determine the best course for their facility. The monograph presents three different approaches to upgrading from the 2000 edition to the 2009 or 2012 edition, depending on whether it is being applied to a new hospital, and existing hospital with Joint Commission accreditation, or an existing hospital certified by CMS.

Information on waivers and equivalencies for using the newer editions of the code are also included, along with sample letters for seeking waivers and equivalencies to allow organizations to use the 2009 or 2012 edition of the Life Safety Code for a project.

The monograph is currently available online and is free to ASHE members. Printed copies will be available for purchase at the online ASHE store soon.

Live Learning Center Bringing the Power of Learning to Your Door

If your budget doesn’t allow travel, lodging, or conference fees to a national event, ASHE has an opportunity to bring the event to you through its Live Learning Center.

You can enhance your learning library with a multimedia recreation of a conference event right at your desktop.

For example, you can purchase the full conference program from the recent 50th ASHE Annual Conference held this past July in Atlanta for $225.

Individual Concurrent Sessions are $20 each and Individual Plenary Sessions are $50 each. The entire list of sessions from this, and many other ASHE Conferences, can be reviewed online.

This is a great way to enhance learning opportunities for you and your staff. Go to Live Learning Center.

ASHE’s LISTSERV Resources Via E-mail

A benefit of ASHE membership is its active LISTSERV, an online, via e-mail, resource to ask questions and share information with other LISTSERV participants.

Members must sign on to be part of the LISTSERV and there are many guidelines designed to maintain the professionalism and integrity of communications. (For instance, vendors are not allowed to sell products or services on the list.)

The LISTSERV is really members helping members. A recent post had a member say, “There have been citations in my hospital for not testing the temperature/humidity in the ORs on a daily basis. I can find nothing in standards that requires daily testing. Any suggestions where I might find the requirement?”

Within the day, the posting had seven helpful replies. Go to LISTSERV
Joint Commission Creates National Safety Goal on Clinical Alarms

The Joint Commission is creating a new National Patient Safety Goal on clinical alarm safety in hospitals and clinical access hospitals. The Joint Commission says clinical alarms are intended to alert caregivers to potential problems but often compromise patient safety if not properly managed.

Under the new safety goal, which is effective Jan. 1, hospital leaders will establish alarm safety as a hospital priority in 2014, and hospitals will identify the most important alarm signals to manage.

Starting in 2016, hospitals will be expected to establish policies and procedures for managing alarms, including clinically appropriate settings for alarms, times when alarm signals can be disabled, and circumstances that permit alarm parameters to be changed.

More information is available in The Joint Commission’s prepublication requirements.

Benchmarking 2.0 Available

Hot off the presses is Benchmarking 2.0: HealthCare Facility Management Report, a self-report survey of ASHE, IFMA, and CHES members on their facility operations, including key business information healthcare facility managers should collect to demonstrate how facility operations contribute to their organization’s core mission.

Facility managers can use the data presented to compare the performance of their facilities with others having similar characteristics and identify areas for improvement.

With data from 262 hospitals and other healthcare facilities, the report includes facility description information as well as data on utilities, maintenance, risk management, and other categories. The data is presented in charts and tables to allow easy identification of where a facility ranks in relation to those included in the survey. Available to ASHE members for $128.

Go to Benchmarking.

Joint Commission Gold Seal

The Gold Seal of Approval is given to accredited organizations in recognition of their efforts to provide high-quality care, treatment, and services. Organizations receive and can display the Gold Seal when they have successfully completed their accreditation survey under the full set of standards, which is the second survey in the early survey.

Organizations receive Preliminary Accreditation after successfully completing their first survey in the early survey process, which does not include the full set of standards.

Effective July 1, 2013, organizations in Preliminary Accreditation may no longer display the Gold Seal. However, these organizations will still be listed on Quality Check® (without the Gold Seal) at http://qualitycheck.org.

Harvard School of Public Health Releases Self-Assessment Tool

A new self-assessment tool provides hospitals with a means of evaluating decontamination plans and capabilities against current regulatory standards, recommendations from subject matter experts, and national and international healthcare decontamination best practices.

The Hospital Decontamination Self-Assessment Tool helps hospitals plan for, and respond to, small and large-scale incidents requiring the decontamination of patients contaminated by or exposed to chemical, biological, radiological, or nuclear agents.

The tool is intended for use by hospital emergency preparedness planners, hospital decontamination team members, and other personnel with a responsibility for their facility’s decontamination plans and procedures.

Go to Self-Assessment Tool.

How Joint Commission Life Safety standards relate to NFPA Regulations


$189 for accredited organizations.

Go to Life Safety Book.

On Track for New Labeling Requirements?

In its efforts to standardize labeling, OSHA has announced required changes to labeling hazardous materials with a new look of standardized pictograms and labels. This universal labeling for all hazardous materials will be identified worldwide removing any need for translating labels, eliminating or reducing misidentification of materials, and providing quick visual recognition to staff.

An article in the July issue of EC News, “Labeling the Hazard - OSHA to institute ‘global harmonization’ of hazard communications” discusses the requirements of transitioning to the new OSHA required labeling of hazardous materials. The article provides information regarding required changes as well as a copy of the required labels and pictograms.

Also included in the article is information on which Joint Commission standards are affected by these changes and what is required. This will help staff universally find and understand information needed to enable both staff and patient safety.

All training for use of new labeling must be completed by December 31, 2013, and the deadline for updating all labeling is June 1, 2015.

For more info, Go to EC News or to Who Changed My Chemical Labels? A presentation by Adam Lomartire, CSP, Tighe & Bond, given at the NEHES Spring Conference.

Listen to 5 TJC Podcasts

Why RPI works

Robust Process Improvement is The Joint Commission’s blended approach to problem-solving. Find out why it works from Dawn Allbee, director of Corporate Robust Process Improvement at The Joint Commission. (8:10)

Quality Through the Eyes of a Patient

Jerod Loeb, Ph.D., executive vice president of Healthcare Quality Evaluation, TJC, says he didn’t really understand quality and safety until he was diagnosed with cancer. (7:15)
and energy use reporting and tracking. Randums of understanding with utilities, including strategic goal production by 2020. BMC will implement commitment to help meet the Boston Climate Pledge. With this pledge, BMC joins to sign the new Renew Boston Pacesetters. It will become the first institution from any sector area. Communities they serve in the Boston climate mitigation and adaptation to the efficiency, renewable energy, and delivery. This Commission is focused on energy reduction, facility awareness, and service growth, and a historical 1.5%/year load growth pattern. Monthly working meetings of facility directors from all the hospitals typically advance:

- Sharing of best practice case studies and strategies for energy efficiency
- Energy efficiency and clean energy policy
- Leverage alternative financing, incentives, and ROI tools
- Coordinated research on clinical equipment energy consumption, in preparation for asking the manufacturers, such as GE, Siemens, etc. to create more efficient equipment
- Ensure energy/climate action is part of community health improvement programs
- Promote & Implement renewable energy systems

For more information, Go to Boston Green Ribbon. Here you will find a list of the 20 Boston participating hospitals.

**Boston Green Ribbon Commission**

This Commission is focused on energy efficiency, renewable energy, and delivering the significant health benefits of climate mitigation and adaptation to the communities they serve in the Boston area. In 2011, Boston Medical Center became the first institution from any sector to sign the new Renew Boston Pacesetter Pledge. With this pledge, BMC joins with Mayor Thomas M. Menino in a commitment to help meet the Boston Climate Action Plan’s energy goals of a 25% reduction by 2020. BMC will implement seven executive and institutional actions, including strategic goal-setting, memorandums of understanding with utilities, and energy use reporting and tracking.

All the major Boston area hospitals, encompassing over 65 buildings with 23 million square feet of owned space, have entered 2008 through 2012 energy and facility data into EPA’s Energy Star Portfolio Manager, completing a first-in-the-nation healthcare metro area energy and Greenhouse Gas (GHG) assessment. For 2012, healthcare GHG emissions are down 5%, overcoming facility and service growth, and a historical 1.5%/year load growth pattern. Monthly working meetings of facility directors from all the hospitals typically advance:

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**ASHE E2C Program**

The American Society for Healthcare Engineering (ASHE) of the American Hospital Association is recognizing the hospitals’ efforts as part of its Energy Efficiency Commitment (E2C) program. The program encourages hospitals across the country to reduce their energy consumption by 10 percent or more over a 12-month period in support of the goals of the Environmental Protection Agency’s ENERGY STAR® Challenge. ASHE outlines many hospital energy-saving strategies on its recently expanded Sustainability Roadmap website. Go to E2C Program.

**Nation’s Second Mattress Recycling Bill Signed into Law in Rhode Island**

Rhode Island Governor Lincoln Chafee recently signed legislation into law that will create the nation’s second mattress recycling program.

The legislation tasks mattress manufacturers in Rhode Island with creating an organization to responsibly collect and process discarded mattresses throughout the state. The new law requires mattress manufacturers to propose a detailed plan for mattress recycling in Rhode Island by July 1, 2015. The program will create opportunities for all mattresses in Rhode Island to be recycled and will help combat the issue of illegally dumped mattresses. Go to Mattress Recycling.

**EPA 2013 Merit Award Winners**

Beth Israel Deaconess in Boston, MA and Cary Medical Center, in Caribou, Maine, have been awarded the 2013 Merit Award from the EPA. Beth Israel is being recognized for its vibrant program of energy reduction. The hospital’s recycling efforts have increased from 20 to 33% thanks to targeted efforts. It reduced paper consumption and junk mail, and promoted reusable mugs so their use jumped from 1 to 25 percent of cafeteria drink sales. They’ve experienced an 8.8% drop in water use and employees commuting alone has dropped from 43 to 36%. Cary Medical Center is being recognized for its Safe Sharps Disposal Program that began in 2011 with collection kiosks in local police stations. State law allows medical sharps in hard plastic containers in household trash, but the Cary program allows for a separate disposal system. This educates the public on the dangers of sharps and protects solid waste personnel.

Within a year and a half of running the program, more than two tons of sharps had been collected. Go to EPA Merit Awards.

**Healthcare Part of President’s Climate Action Plan**

Healthcare is specifically mentioned in the President’s Plan announced in June. The Department of Health and Human Services will launch an effort to create sustainable and resilient hospitals in the face of climate change.

Through a public-private partnership with the healthcare industry, it will identify best practices and provide guidance on affordable measures to ensure that our medical system is resilient to climate impacts. It will also collaborate with partner agencies to share best practices among federal health facilities.

It will help train public health professionals and community leaders to prepare their communities for the health consequences of climate change, including effective communication of health risks. Go to President’s Climate Action Plan.

Yale-New Haven Hospital (YNHH) and Rock and Wrap It Up! have teamed up to launch Hospital Wrap! This sustainability program recovers food that has been prepared but not served from YNHH and donates it to those in need throughout the South Central Connecticut area.

Beginning this month, YNHH will donate food through the Hospital Wrap! program to the Community Soup Kitchen at Christ Church and St. Luke’s Episcopal Church in New Haven as well as St. Ann’s Soup Kitchen in Hamden.

The food will be collected and dispersed through their agencies. The program will also eventually provide these agencies with support to help decrease landfill use. Go to Hospital Wrap.

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No More Objections - Objections Wane As Case for Sustainability Strengthens

Bill Conley, IFMA Fellow, CFM, SFP, FMP LEED AP tackles the subject of sustainability in this pointed article in the July/August 2013 issue of The Facility Management Journal, a publication of the International Facility Management Association (IFMA).

Excuses and rationalization are easy ways out of facing or implementing change, especially one as daunting as the major overhaul of practices that encompasses sustainability. However, it is perhaps not change which presents the problem for building a sustainable world, but the fear of change.

Whether they want to accept it or not, people tend to assume that the status quo, the way things are, is somehow right and natural; a perspective that drives them to instinctively reject visions of the future if it signifies a meaningful shift from present reality.

For complete article, go to No More Objections.

New OSHA Rules For Floor Safety
Taken from Cleaning & Maintenance Management by Russell Kendzior

In August 2013, the U.S. Department of Labor’s Occupational Safety and Health Administration (OSHA) is scheduled to release new rules for Walking and Working Surfaces (29 CFR Part 1910), that raise the bar for floor care, safety and inspection.

Subpart D of 29 CFR part 1910, Walking and Working Surfaces … “sets forth general industry requirements for employers to protect employees from slips, trips and falls…”

In developing revised rules, OSHA held hearings and conducted extensive scientific and technical research to inform a definitive approach to help protect workers from slips, trips and falls. OSHA consulted sources such as the National Bureau of Standards (now the National Institute of Standards and Technology) and the American National Standards Institute (ANSI), which the agency used to develop the proposed revisions to subparts D and I.

These studies established a foundation for OSHA’s earlier traction recommendations to help ensure a safe walkway, however, no coefficient of friction (COF) value was ever required or enforced by OSHA; a non-mandatory coefficient of friction is listed in the appendix of OSHA rules.

Although the earlier rules were authoritative in the 1980s at the time of development, OSHA felt that, due to significant increases in the reported number of workplace falls, it was time to revise their requirements.

Under the proposed new rules, OSHA will now require that: “Only qualified persons shall be permitted to inspect, maintain or repair walking and working surfaces…”

OSHA defines a qualified person as one “capable of identifying existing or potential hazards in specific surroundings or working conditions which may be hazardous or dangerous to employees; and has been trained for the specific task assigned.”

For complete article, go to Floors.

LEED v4 Rating System Approved

The U.S. Green Building Council (USGBC) recently approved its LEED v4 rating system.

Healthcare Design Advisory Board member Kim Shinn, a LEED Fellow and principal and senior sustainability consultant noted “I’m confident in saying that the approval of v4 provides opportunities for healthcare to continue as leaders in green building.”

Shinn explains, “the market has plenty of time to absorb” the changes in LEED HC v4. And most of those changes, he says, simply adopt new reference standards that are already being widely used, such as those in ASHRAE 90.1-2010 and the International Energy Conservation Code 2012.

Not everyone is content with LEED v4, however. Some materials manufacturers, including the Vinyl Institute, have expressed concern over the language in the guidelines. “While the goal of the LEED v4 Materials and Resources credits is to encourage the use of products and materials that have environmental, economical, and socially preferable life cycle impacts is admirable, the nuances, and in some places oversimplification, of the MR credits could cause the opposite effect,” says the group’s president and CEO, Dick Doyle.

The institute also challenges language regarding materials such as PVC, which it says “fails to account for comparative life cycle and risk/exposure assessments.” For complete article, Go to LEED

Moody’s: Hospital Expenses Outpace Revenues for First Time in Three Years

Expenses grew faster than revenues for not-for-profit hospitals in fiscal year 2012, according to a report released by Moody’s Investors Service, a situation the credit rating agency calls “unsustainable.”

Expenses grew by a median 5.5% for 402 hospitals and health systems rated by the agency, while median operating revenues grew just 5.2%.

Moody’s expects operating performance for the sector to remain weak.

“We expect revenue growth will remain pressured in FY 2014 following the Centers for Medicare & Medicaid Services’ final ruling that hospitals will receive a slim 0.7% net increase on inpatient reimbursement rates in federal FY 2014,” writes Deepa Patel, Moody’s assistant vice president/analyst. “The continued sequestration and Medicare disproportionate share reductions that begin on Oct. 1, 2013 will also hamper performance. Most management teams will respond aggressively with expense growth containment strategies to combat limited revenue growth. However, it will be difficult to make swift expense reductions since many cost savings measures have been exhausted following the recession.”

Got a Question About Joint Commission Standards?

Go to Standards FAQs to look for answers to a variety of questions. Didn’t find an answer? Go to Online Submission Form to ask your own question.
Improving America’s Hospitals - The Joint Commission’s Annual Report on Quality and Safety

The 2012 report includes 620 hospitals, designated as Top Performers on Key Quality Measures™, that are leading the way nationally in using evidence-based care processes closely linked to positive patient outcomes. The hospitals identified as attaining and sustaining excellence in accountability performance in 2011 represent approximately 18 percent of Joint Commission-accredited hospitals reporting core measure performance data.

The annual report also summarizes the performance of more than 3,300 Joint Commission accredited hospitals on 45 accountability measures of evidence-based care processes closely linked to positive patient outcomes. While the data show impressive gains in hospital quality performance, improvements can still be made. Some hospitals perform better than others in treating particular conditions.

Overall, the report shows 88.8 percent of hospitals achieved a composite accountability measure performance of 90 percent in 2011, compared to 20.4 percent of hospitals in 2002.

For Complete Report, Go to Report

Take A Walk On The Wild Side

You know all about the benefits of nature (whether experienced visually or up close and personal) on patient outcomes. It’s good for the staff, too, not to mention the neighborhood. But now, research is starting to take a closer look at what kind of nature promotes health and well-being the best. Is it smooth, golf-course-like expanses and meticulously arranged annuals? What about prairie-style vistas, with tall grasses waving in the breeze and wildflowers popping up (seemingly) at random?

Past research, not necessarily health care-specific, has suggested that we humans prefer our landscapes to be less “messy.” And that might be because wild-looking areas with tangled underbrush, and lots of places for scary things to hide, trigger our evolutionary survival instincts.

But that doesn’t mean we always want putting greens, either. As other research shows, a sort of controlled chaos, where it’s clear that a loose interplay of plantings is on purpose and carefully tended, makes people pretty happy, too.

In the July 2013 issue of Healthcare Design, University of Denver adjunct professor Angela Loder and landscape architect Jerry Smith delve deeper into the research, including Loder’s own recent doctoral studies, and offer some thoughtful advice for how to approach natural spaces in healthcare settings.

Her research showed that while some visitors found the space “beautiful,” many others “didn’t like the messy look of the green roofs and associated it with neglect.” As Loder and Smith explain in the article, “This supports work in the social sciences on the social and cultural impact on our values and perceptions of nature in the city … showing that ideas of modernity, progress, and sanitation mean we associate messy in the city with ‘bad,’ ‘unhealthy,’ and ‘poor.’”

High Reliability Recognized in Bridgeport, Connecticut

To reach the goal of zero harm, healthcare organizations are employing the principles of high reliability organizations. In a monograph published last year, The Joint Commission profiled St. Vincent’s Medical Center in Bridgeport, Conn., as having a best practice for linking patient safety and worker safety.

Safety at St. Vincent’s is not viewed as a ‘program’ but rather the core foundation of their work; a job that will never be completed. This focus on safety has translated into savings, both in dollars and human terms. For example, the hospital had a 22 percent decrease in needlesticks and a 30 percent decrease in serious employee falls in 2012 compared with 2011.

As you may know, The Joint Commission began its focus on the transformation of healthcare into a high reliability industry in 2009. High reliability is defined as consistent performance at high levels of safety over long periods of time. In other words, highly reliable healthcare is care that is dependably excellent, every time, for every patient.

To learn more, go to High Reliability,

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