



# MISHE NEWS

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**Pier-George Zanoni, PE**  
**MISHE Newsletter Editor**

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## MiSHE Annual Conference

The Annual Conference will soon be here. September 22<sup>nd</sup>, 23<sup>rd</sup>, and 24<sup>th</sup> should be marked on your calendar and you should [click here](#) to register for the conference. Visit the MiSHE web and click on the Annual Conference link to read the agenda, info and bios of speakers that are listed. Over the next few weeks, breakout presentations will be posted, as well.

As always, there will be ample time to network. Wednesday, kicks off the conference with many opportunities to converse, share, and gather information from other members. Golf and fishing will begin the networking sessions and the “Member Reception” will be the culmination of events of the day. Food and refreshment will be entertained with information and awards for the activities of the day!

Our Keynote speaker, York Chan, ASHE Region 5 Representative will have an energy-packed opening that will give us a perspective on the evolving healthcare industry.

This year the conference theme is “Adapting to Reforms in Healthcare.” Reforms are essentially changes. The “reforms” highlighted in this conference are changes in thinking about energy, changes in policy about infectious disease transmission and humidity levels, and changes how we communicate using wireless devices.

The conference ends on Friday with our “regulatory” theme. The Keynote will be Richard Gudkese, TJC, who will discuss standards that seem to be the hardest to attain. The conference will end by noon after updates from Fire Safety and Health Facilities.

To see more information about the Annual Conference, [click this link](#).

## ASHE Recognizes Five Hospitals for Energy Reduction

In observance of Earth Day, the American Society for Healthcare Engineering (ASHE) of the American Hospital Association recognized five hospitals for their reduction in energy consumption. ASHE's Energy Efficiency Commitment (E<sup>2</sup>C) program encourages hospitals across the country to reduce their energy consumption by 10 percent or more in support of the goals of EPA's ENERGY STAR<sup>®</sup> Challenge. ASHE recognizes the following hospitals for their leadership reducing energy consumption:

- St. Mary's Medical Center - Blue Springs, Mo.
- Advocate Trinity Hospital - Chicago
- Advocate Good Shepherd Hospital - Barrington, Ill.
- University of Arkansas for Medical Sciences - Little Rock
- Shriners Hospital for Children - Salt Lake City



For information on the E<sup>2</sup>C program, please [click here](#).

Editor's note: Many Michigan hospitals have been aggressively reducing their energy consumption through innovative physical plant retrofits and upgrades. Several of these have been featured in the recent quarterly newsletter for the Michigan Green Healthcare Committee. Visit the MGHC committee's web page and click on the link under the

Newsletter section. See [http://www.mha.org/mha\\_app/public\\_site/mghc.jsp](http://www.mha.org/mha_app/public_site/mghc.jsp) .

MISHE members are encouraged to participate in the ASHE E2C program. Stand up and be recognized!

## Gregory Cole Receives Internship Award

Gregory Cole is the most recent recipient of the Internship Award offered by MiSHE. The award requires that the intern be required to do an internship as part of the degree or by their program of study. The internship must be done in a MiSHE-member healthcare



institution. Mr. Cole is interning within the Spectrum Health system and being mentored by Brian Crum, a MiSHE Member of the South West Regional Chapter.

Gregory is attending Ferris State University and is enrolled in the Facilities Management program. His internship is the last semester of work before completing his degree. He will graduate in December 2010.

**The award was presented on June 18<sup>th</sup> at the MiSHE Board meeting. As part of the award requirements, Gregory will be in attendance at the MiSHE Annual Conference and may be requested to make a presentation about his intern experience. We all hope to see him at the conference and in the future as a healthcare manager!**

## Reporting required?

**Hospitals and EPA's new greenhouse gas rule**

From: **Health Facilities Management**

*This article first appeared in the April 2010 issue of HFM.*

Article Location:

[http://www.hfmmagazine.com/hfmmagazine\\_app/jsp/articledisplay.jsp?dcrpath=HFMMAGAZINE/Article/data/04APR2010/1004HFM\\_FEA\\_CS](http://www.hfmmagazine.com/hfmmagazine_app/jsp/articledisplay.jsp?dcrpath=HFMMAGAZINE/Article/data/04APR2010/1004HFM_FEA_CS)

By Mitchell M. Wurmbrand and Thomas C. Klotz

In late 2009, the Environmental Protection Agency (EPA) issued a new rule addressing greenhouse gas (GHG) emissions reporting. The information EPA has published to support the "Mandatory Reporting of Greenhouse Gases Rule" states that EPA believes the majority of smaller GHG-emitting facilities will not have to report. However, there is uncertainty about where some institutions may fall.

To determine whether a hospital is subject to the rule, which can be accessed by [clicking here](#), a number of factors must be considered.

**CODES+STANDARDS**

### Reporting required?

Hospitals and EPA's new greenhouse gas rule

BY MITCHELL W. SHERRARD AND THOMAS C. KLOTZ

In late 2009, the Environmental Protection Agency (EPA) issued a new rule addressing greenhouse gas (GHG) emissions reporting. The information EPA has published to support the "Mandatory Reporting of Greenhouse Gases Rule" states that EPA believes the majority of smaller GHG-emitting facilities will not have to report. However, there is uncertainty about where some institutions may fall.

To determine whether a hospital is subject to the rule, which can be accessed by [clicking here](#), a number of factors must be considered.

**Rule applicability**

Reporting requirements under the final rule will apply not only to certain fossil fuel suppliers and manufacturers of certain vehicles and engines, but also to certain downstream facilities that emit 25,000 metric tons per year of carbon dioxide equivalent (mtCO<sub>2</sub>e) of GHG emissions. It is under this broad umbrella of downstream facilities that some hospitals may be included.

The reporting rule defines a "facility" as "any physical property, plant, building, structure, source, or stationary equipment located on one or more contiguous or adjacent properties in actual physical contact or separated solely by a public roadway or other public right-of-way and under common ownership or common control, that emits or may emit any greenhouse gas." A hospital campus is considered a single facility if the structures are located on contiguous or adjacent properties and are under common ownership or common control. The buildings do not have to be connected by walkways, tunnels or pipelines to be considered a single facility. Even if the structures are separated by a public road, they would still be considered contiguous. This definition broadens the scope of the reporting rule and differs from how a facility may be defined under other environmental regulations. Hospitals may be regulated under this rule because they operate stationary fuel combustion units that are listed in Part 98.2(a)(3) of the rule. A stationary fuel combustion source is a device that combusts any solid, liquid or gaseous fuel generally to produce electricity, steam, useful heat or energy for industrial, commercial or institutional use or reduces the volume of waste by removing combustible matter. These devices include, but are not limited to, boilers, engines, process heaters, combustion turbines and incinerators. The rule excludes portable equipment, emergency generators, emergency equipment, agricultural irrigation pumps, hazardous waste combustors (except for co-fired fossil fuels), flares and research and development activities.

EPA has not set a minimum heat input capacity level below which a stationary fuel combustion unit does not have to be included in a facility's calculation of annual GHG emissions. As a result, every piece of nonexcluded, fossil-fuel-fired stationary equipment, regardless of size, must be accounted for. This includes devices such as space heaters and rooftop units that burn fossil fuel.

If a hospital operates stationary fuel combustion sources, the rule requires health facilities professionals to determine if the facility emits 25,000 mtCO<sub>2</sub>e or more from stationary combustion in any calendar year starting in 2010. If so, GHG emissions from stationary fuel combustion devices must be reported. However, if the maximum rated heat input capacity for all stationary fuel combustion equipment combined is less than 30 million British thermal units per hour (mmBtu/hr), the facility is presumed to emit less than 25,000 mtCO<sub>2</sub>e, and health facilities professionals do not have to calculate or report emissions. If a facility has an aggregate maximum rated heat input capacity equal to or greater than 30 mmBtu/hr, the facility will need to complete further calculations to determine if it meets the threshold for reporting.

It is likely that many hospitals exceed this 30 mmBtu/hr threshold. Those facilities will, at a minimum, need to calculate their historical annual mtCO<sub>2</sub>e emissions to see if the facility can be expected to exceed the GHG reporting threshold.

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### Estimating and reporting

For facilities that exceed the 25,000 mtCO<sub>2</sub>e reporting threshold, facilities professionals must report annual emissions of carbon dioxide (CO<sub>2</sub>), methane (CH<sub>4</sub>) and nitrous oxide (N<sub>2</sub>O) for each fuel combusted.

EPA has prescribed specific calculation methodologies within the reporting rule for estimating emissions. To address the proper level of reporting rigor, EPA developed four calculation options, or tiers, that may be selected based on combustion unit size, type of fuel burned and other factors.

For example, Tier 1 represents a simplified calculation methodology where company records may be used to determine fuel use and default emissions factors, and fuel high heating values may be used to estimate emissions. Tier 4 methodology presents the opposite end of the spectrum and requires a continuous emission monitoring system (CEMS) for estimating emissions from certain units. Tiers 2 and 3 use combinations of the simplified and complex approaches.

Generally, all combustion units with a rated heat input capacity of 250 mmBtu/hr or less are allowed to use the simpler Tier 1 or Tier 2 calculation methodologies. Certain combustion units with input ratings above 250 mmBtu/hr that combust pipeline quality natural gas and distillate oil are also allowed to use Tier 2. However, units rated above 250 mmBtu/hr that combust residual oil, other gaseous fuels, and solid fossil fuels will need to apply the Tier 3 or Tier 4 methodologies.

Depending upon the chosen method, some facilities will need to comply with requirements for conducting fuel sampling and analysis, and installing/calibrating monitoring devices (e.g., fuel flow meters). It is likely that most hospitals will be able to use Tier 1 or Tier 2 calculation methodologies.

As an option, EPA will allow many facilities to aggregate emissions reporting from individual units with maximum rated heat input capacities less than 250 mmBtu/hr. Units may also be aggregated based on the use of a common fuel supply line or pipe or a common stack or duct configuration where CEMS are used.

While this may provide some relief for many reporting facilities, there are a few particularly burdensome requirements that remain, including the obligation to report an identification number for each combustion unit reported in a group and the cumulative maximum rated heat input capacity of the group (mmBtu/hr).

Consequently, regardless of whether a health facility elects to report by individual unit or multiple units aggregated by group, the facility will likely need to prepare a comprehensive stationary fuel combustion equipment inventory for all nonexcluded combustion units. The development of a combustion equipment inventory could be complicated for facilities that employ the use of many smaller combustion units.

One particularly time-sensitive requirement within the reporting rule is the written GHG monitoring plan, which affected facilities are required to have in place this month. The monitoring plan is expected to identify individuals responsible for the collection of emissions data; explain the methods used to collect data and perform emission calculations; and describe the procedures used for quality assurance, maintenance and repair of monitors and other instrumentation.

The plan may rely on references to existing documents (e.g., standard operating procedures and quality assurance programs) and, as such, EPA has not prescribed a specific format. Facilities are not required to submit the monitoring plan to EPA for approval, but must retain the plan in accordance with the record-keeping requirements.

### **Other key aspects**

There are a number of general provisions and other key aspects that should be carefully considered by reporting facilities. They include the following:

- Facilities subject to reporting should have initiated data collection and recordkeeping activities on Jan. 1, 2010.
- The first annual GHG report is due March 31, 2011.
- Records must be retained for at least three years.
- Records must be available to EPA for review upon request.
- A single individual should be made responsible for certifying, signing and submitting GHG emission reports.
- Revisions to a report submitted to EPA must be provided within 45 days of discovery or notification by EPA.

Once a health facility is subject to the reporting rule, it must continue to report each subsequent year, even if the facility does not exceed thresholds during future reporting years. EPA allows facilities to cease reporting after five consecutive years if reported emissions are less than 25,000 mtCO<sub>2</sub>e or after three consecutive years if reported emissions are less than 15,000 mtCO<sub>2</sub>e.

Additionally, EPA reserves the option to verify the completeness and accuracy of GHG emissions reports and may take enforcement action for any violation of a reporting rule requirement. GHG regulatory enforcement likely will be a high priority of the EPA in the short term.

### **Evaluating responsibility**

Health facilities professionals will need to evaluate their responsibilities under EPA's GHG reporting rule.

It may be that many smaller hospitals will not have to report their GHG emissions to EPA. It is also likely, however, that most hospitals will need to calculate their emissions to document them.

**Mitchell M. Wurmbrand** is an associate principal and certified consulting meteorologist in the Bloomfield, Conn., office of Norwood, Mass.-based GZA GeoEnvironmental Inc. His e-mail is [Mitchell.Wurmbrand@gza.com](mailto:Mitchell.Wurmbrand@gza.com). **Thomas C. Klotz** is a project manager in GZA's Livonia, Mich., office. His e-mail is [Thomas.Klotz@gza.com](mailto:Thomas.Klotz@gza.com). The opinions expressed in the article are the authors' own.

### **Sidebar - Origins of the GHG reporting rule**

Hidden away in the fiscal year 2008 Consolidated Appropriations Act was a provision for the Environmental Protection Agency (EPA) to develop a rule "to require mandatory reporting of greenhouse gas (GHG) emissions above

appropriate thresholds in all sectors of the economy of the United States."

In April 2009, EPA proposed the "Mandatory Reporting of Greenhouse Gases Rule." The purpose of the rule is to provide EPA with the data it will need to make future policy decisions regarding GHGs and climate change.

During the official 60-day comment period and beyond, the EPA held public hearings, received nearly 17,000 written comments, met with 4,000 individuals and 135 groups. A little over five months after publishing the proposed rule, the EPA issued its final rule on mandatory GHG reporting.

The rule was then published in the Federal Register on Oct. 30, 2009, and went into effect 60 days later.

### Sidebar - Checking facility applicability

If a health care facility operates stationary fuel combustion sources that, in the aggregate, exceed 30 million British thermal units per hour heat input capacity, the table below provides a rule of thumb for how much fuel must be consumed on an annual basis to exceed 25,000 metric tons per year of carbon dioxide equivalent.

#### ANNUAL GHG EMISSIONS BY FUEL TYPE AND QUANTITY

Fuel type	Annual fuel consumption	Annual GHG emissions
Natural gas	459 million scf	25,018 mtCO <sub>2</sub> e
No. 2 fuel oil	2.45 million gallons	25,027 mtCO <sub>2</sub> e
No. 6 fuel oil	2.22 million gallons	25,029 mtCO <sub>2</sub> e

Note: GHG = greenhouse gas; scf = standard cubic feet; and mtCO<sub>2</sub>e = metric tons per year of carbon dioxide equivalent.

For a more exact estimate, the Environmental Protection Agency has provided an easy-to-use "Applicability Tool" on its Web site to assist facilities with determining whether the reporting rule is applicable. While a more thorough follow-up analysis may be necessary for some, this tool can help many make final decisions. It can be accessed at

[www.epa.gov/climatechange/emissions/GHG-calculator/index.html](http://www.epa.gov/climatechange/emissions/GHG-calculator/index.html).

## Healing an Ailing System

Steam generators help Mount Clemens hospital save money and conserve energy

By Glenn Adgey

For 65 years, Mount Clemens Regional Medical Center has been a staple in Macomb County, Michigan, not only as a premier healthcare facility, but also as the area's top employer. The Medical Center has grown from 40-bed facility, with about as many doctors on staff, to a 288-bed acute care hospital with a number of offices and medical buildings and more than 460 physicians and 2,600 employees. It is a major part of the community it serves and its teaching program also attracts hundreds of students from around the country.

But, like other hospitals throughout the United States, in order to stay solvent, Mount Clemens needed to find ways to improve performance and cut costs. So, in 2006, it looked to Siemens Building Technologies and its Integrated Performance Solutions Program to audit and find ways to contain energy costs.

## Significant Savings Realized

The program provides a comprehensive building plan customized to meet the needs of the individual client. In this case, Siemens experts focused on energy efficiency. Nearly four years since the audit, the energy makeover has amounted to a huge savings for the hospital, thanks to major changes to the physical plant's power, lighting, HVAC and water systems.



“Prior to the audit, Mount Clemens Regional Medical Center boiler plant consisted of four high-pressure steam boilers; two 400 HP units that provided wintertime heating load and two 300 HP units that provided the summer thermal loads,” explained Keith Miller, Director of Facilities Management at Mount Clemens. Siemens experts knew this system needed to be replaced with something that ran cleaner, simpler and more consistently. They looked to Clayton Industries to replace the old boiler with a vertical steam generator.

The two existing 300 HP Johnston gas-fired boilers and burners were removed, as well as all of their accessories and accompanying equipment to accommodate the new gas-fired steam generators. The new units were a 300 HP generator and a 500 HP one. Miller said almost immediately after the installation, Mount Clemens enjoyed an improvement in overall plant efficiency. “After the installation of the Clayton Steam Generators, we measured the monthly steam flows from the generators and compared those to what would have been the actual amount of gas used—and billed for—had we stayed with our old boiler systems,” Miller said. “What we saw was that the medical center’s total gas savings was roughly 50,000 MCF for the first year for a cost savings of over \$433,312. The gas savings came from an improvement in the plant’s overall efficiency.”

According to Siemens Energy Engineering Manager Keith Kazan, Mount Clemens saw dramatic increases in energy efficiency. Plant efficiency rose from about 47.2 percent with the old boiler system to 84.2 percent with the steam generators. “With the proper applications and requirements, it definitely makes sense to change over from a traditional boiler system to a steam generator, like those manufactured by Clayton Industries,” Kazan said. “I would absolutely make the same recommendations to other facilities, like these two hospitals.”

### Steam Generation Saves Time, Energy, Dollars

So, what makes a steam generator that much more energy efficient? First, these units heat up faster, within about 15 minutes as opposed to a conventional boiler, which takes between two and three hours. They can also be turned on and off when needed without the risk of damage to the system. Hospitals are required to have back up generation, which when the plant is run with a conventional boiler, it is generally kept in hot mode so it comes on-line quickly, if need be. That means that even if the hospital is not currently using the back-up boiler, it is consuming energy, just in case it is needed.

According to Miller, because the steam generator starts so quickly, it can be kept turned off until needed. “With the steam generators, steam production is nearly instantaneous. It allows us the ability to not have a fire tube boiler on standby in case of an emergency. If we were to have an issue with our primary system, the operators are able to get the second system up to full steam in less than 15 minutes.” In addition, hospitals have fluctuating, seasonal loads and under conventional boiler methods sometimes operate in low fire or low load for a considerable time—a very inefficient process. Clayton’s operating efficiency averages 85 percent, no matter what the load or firing rate. The generator’s design creates less heat loss and chemical loss. What’s more, the steam generators are explosion-proof, providing the highest level of safety in the boiler industry. Miller said another major benefit using steam generation is minimal maintenance.

He said as long as general maintenance procedures are followed, preventive maintenance is fractional, compared to that of traditional fire tube boilers. “Overall, the steam generators have been a valuable addition to the Mount Clemens Regional Medical Center in our mission to reduce energy consumption and costs,” Miller said.

## ASME Energy Assessment for Steam Systems ASME EA-3-2009

The American Society of Mechanical Engineers has just released the ASME EA-3-2009 Energy Assessment for Steam Systems Standard. The Standard sets forth the requirements for conducting and reporting the results of a steam system energy assessment that encompasses the entire steam system from energy inputs and steam generation and cogeneration through distribution to users and condensate return. A representative from Armstrong International was selected to participate in authoring the standards designed to help industrial, institutional and commercial facilities identify and capture energy efficiencies and optimize the overall performance of their steam system. When you engage Armstrong International for energy engineering services you can be assured every member of our team will follow the ASME guidelines. Moreover, we won't take a "cookie cutter" approach. We will work with you to assess your system and identify your needs. Once your unique needs have been identified, we will review a number of options to meet your short- and long-term requirements. Whatever your individual solution, you can be sure it will be built to meet the highest standards possible. Nashville 500 yr flood Hospitals remain open

## Nashville 500 YR Flood – Hospital Remains Open Vanderbilt. Monroe Carrell Children's Hospitals Flooded

Posted: May 02, 2010 2:28 PM EDT Sunday, May 2, 2010 2:28 PM EST at [NewsChannel5.com](http://NewsChannel5.com)

See <http://www.newschannel5.com/global/story.asp?s=12412401> .

*NASHVILLE, Tenn.* – Patients have been moved at Vanderbilt University Medical Center and Monroe Carrell Children's Hospital after flooding in the basements of both hospitals. Flood waters continued to rise Sunday afternoon on West End in Nashville. Crews were working to pump water out of the hospitals. "The basements continue to be flooded. The Nashville Fire Department is on the scene extracting water from the basement," said hospital spokesperson Jerry Jones. Jones said other than flooding in the basement, hospital operations continued as normal. Hospital officials were working to bring more staff in to help, but they expected several people to have problems to make it away from their homes due to road closures. Accommodations were being arranged for staff members already at the hospitals. Water continued to pour into the hospital basements Sunday afternoon. "We have a steady stream – almost like a river – coming from the Vanderbilt clinic basement and going downhill into the Children's Hospital basement," said Jones. The main lobby, grand staircase and basement of the Children's Hospital were flooded. Water has also flooded into the main hospital's dock area, sub-basement, and emergency room. Jones said hospital staff members were still able to help those with emergency medical needs. "We did have to relocate some patients earlier from the main hospital into another area in the emergency department. Both emergency departments continue to see patients," said Jones. All elective surgeries for Monday have been canceled. Both hospitals continued to admit and see patients, but there was a steady stream of water pouring into the lower levels. Jones said hospital officials were ready to react if the situation got worse. "We have a command center where we have leadership from all areas of the hospital come together so they can quickly assess the information as it comes in and make decisions about patient care and be in contact with city officials at their command center," he said. Jones said the number of incoming patients has slowed, most likely because of the road conditions. Only a few people have been treated for flood-related injuries.

## FCC Rule Would Allow Ham Radio Use During Disaster Drills

The Federal Communications Commission (FCC) will accept comments through May 24 on a [proposed rule](#) allowing licensed amateur radio operators who are employees of hospitals and other organizations to transmit messages during government-sponsored emergency readiness drills. Hospitals accredited by the Joint Commission must test their emergency operations plans twice a year, including how they will communicate in an emergency or disaster. Some hospital emergency plans include the use of amateur (or HAM) radios as backup when traditional means of communication fail. FCC regulations currently prohibit employees from operating amateur stations during drills without a drill-specific waiver from the agency. AHA plans to comment on the proposed rule.

## Historic Change In The Operating Room Environment

[The National Standard for Establishing Relative Humidity in Operating Rooms](#)

[Has Been Reduced to 20%](#) Over the years, relative humidity levels have been a source of continued debate in the health care community. In an effort to debunk an age-old requirement, the ANSI/ASHRAE/ASHE Standard 170: Ventilation of Health Care Facilities Standing Committee applied science, a literature search, and research to this subject and has issued Addendum "d." The ASHRAE 170 Standing Committee has approved this addendum, which will become effective at the end of June 2010. ASHRAE 170 has been incorporated into the 2010 FGI Guidelines for Design and Construction of Health Care Facilities. The publication of this

addendum stresses the aspects of relative humidity in operating rooms in terms of clinical outcomes, comfort, and engineering concepts

Seminar: **New Requirements for Operating Room Humidity Levels** *Be Aware, Knowledgeable, and Ready to Respond*

At the end of June, new requirements for humidity levels in the operating room take effect as a result of actions taken by the ASHRAE Standing Committee responsible for continuous maintenance of ANSI/ASHRAE/ASHE Standard 170: Ventilation of Health Care Facilities. A literature search and scientific research were applied to the question of appropriate humidity levels in short-stay patient areas. As a result, Addendum "d" to Standard 170 was approved by the ASHRAE 170 Standing Committee. Publication of this addendum stresses the aspects of relative humidity in operating rooms in terms of clinical outcomes, comfort, and engineering concepts.

ASHRAE 170 has been incorporated into the 2010 FGI Guidelines for Design and Construction of Health Care Facilities, which is used to regulate health facility design and construction. To make sure you understand what humidity levels will be expected and are prepared to share this information with staff who will be affected by this change, join us for a full-day seminar on June 8. Put on jointly by ASHE and several other organizations, the seminar will provide accurate information on the real issues surrounding humidity levels in the operating room environment. For those unable to attend the on-site program, ASHE will make the live, two-hour panel discussion with questions and answers available online.

#### Continuing Education Credits

5 contact hours pending. This activity has been submitted to the Association of periOperative Registered Nurses, Inc. for approval to award contact hours. The Association of periOperative Registered nurses, Inc. is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Activities that are approved by AORN are recognized as continuing education for registered nurses. This recognition does not imply that AORN or the ANCC Commission on Accreditation approves or endorses any product included in the presentation.

AHA CEU information: 6 contact hours (.60 CEU) for the on-site program (including the live broadcast); or 2 contact hours (.2 CEU) for those participating in only the live Internet broadcast.

[Click here for detailed program and registration information](#)

**Editors note: CMS Life Safety Code survey forms for health care facilities still reference 2005 NFPA 99 Section 6.4.1.1 which requires 35% minimum relative humidity in Operating Rooms.**

## MECH Recertification

As we head toward January 2011, many previously certified mechanics at both the Certified and Senior Certified levels will be asked to recertify. Since, September of 2007, all mechanics have been notified of the recertification requirement. Certified Healthcare Mechanics (CHM) and Senior Certified Healthcare Mechanics (SCHM) will be required to recertify every five years. MECH recertification is not as complicated as other national certifications, but requires the same commitment to maintaining and upgrading technical skills.

Recertification basically involves documenting and verifying that each certificate holder has received a minimum of 6 hours of classroom instruction for each of the 5 years after certifying. Six hours of classroom time per year accumulates to the minimum required number of hours for recertification – 30 hours. It must be restated that each year, there must be a minimum of 6 classroom hours of instruction. Classroom instruction means time spent in training that requires the mechanic to leave his/her regular duties and to spend time focusing on learning something about a process, product, or system.

A recertification fee of \$60 to process the paperwork and reissue a certificate is being charged at this time. Both the documentation and the fee must be received by the MECH National Office before the certificate holder's recertification deadline. The recertification anniversary (or certificate expiration date) is printed on the official certification document. The recertification must occur during the month in which the certification expires. Persons not recertifying by the deadline date will need to take the certification test to retain certification.

Those holding Certified Healthcare Mechanic (CHM) status may want to try for the Senior Certified Healthcare Mechanic (SCHM) level; the highest level of certification. This level requires a minimum of 4 years of experience on the job, in a healthcare facility and an affidavit verifying that experience. At the end of 5 years, a CHM would have acquired the experience and would now qualify to take the next level of certification test. This is the only way to attain the next level of certification – a certificate holder cannot

recertify to the next level! Certificate holders that have been certified before September 2007 were asked to register for recertification. All of those who are registered will also be recertifying starting in January of 2011.

MECH is happy to have satisfied several needs with the recertification requirement. Some of those needs were for certificate holders; some were institutional; and some were national. A few of them are listed below:

- The mechanics need to show continual improvement within his/her profession.
- The mechanics need to have a national certification that required recertification to qualify for pay bonuses.
- A third-party certification that is recognized as having what all national certification programs require.
- An instructionally recognized requirement for training and retraining initiatives.
- The documentation of training requirement for the mechanic, healthcare institution, and national certification service.
- A nationally recognized continual improvement requirement for all certificate holders

## New Mandatory Green Building Code For California (CalGreen)

01/12/2010 GAAS:27:10 FOR IMMEDIATE RELEASE [Print Version](#) | See <http://gov.ca.gov/press-release/14186/>

### Governor Schwarzenegger Announces First-in-the-Nation Statewide Green Building Standards Code

Continuing California's efforts to fight climate change and protect the environment, Governor Arnold Schwarzenegger today announced the California Building Standards Commission unanimously adopted the first-in-the-nation mandatory Green Building Standards Code (CALGREEN) requiring all new buildings in the state to be more energy efficient and environmentally responsible. Taking effect on January

The screenshot shows the CALGreen website interface. At the top, there is a navigation bar with tabs for Home, About BSC, Calendar, Approved Changes, Proposed Changes, Processes, Questions, CALGreen (selected), and CCDA. Below this is a sub-navigation bar with Education and Outreach, Green Code, and SB1473. The main content area is titled 'CALGreen' and features a list of links: '2008 California Green Building Standards Code', '2010 Draft California Green Building Standards Code (Effective January 1, 2011)', 'SB1473 Building Standards Administration Special Revolving Fund', 'Education & Outreach', and 'Green Building Standards Bulletin - BSB 08-02'. On the left side, there is a 'FEATURED LINKS' section with links to 'DGS Home Page', 'Related Sites', 'Feedback', 'Contact Us', and 'Site Map'.

1, 2011, these comprehensive regulations will achieve major reductions in greenhouse gas emissions, energy consumption and water use to create a greener California.

“With this first-in-the nation mandatory green building standards code, California continues to pave the way in energy efficiency and environmental protection. Today’s action lays the foundation for the move to greener buildings constructed with environmentally advanced building practices that decrease waste, reduce energy use and conserve resources,” said Governor Schwarzenegger. “The code will help us meet our goals of curbing global warming and achieving 33 percent renewable energy by 2020 and promotes the development of

more sustainable communities by reducing greenhouse gas emissions and improving energy efficiency in every new home, office building or public structure.”

CALGREEN will require that every new building constructed in California reduce water consumption by 20 percent, divert 50 percent of construction waste from landfills and install low pollutant-emitting materials. It also requires separate water meters for nonresidential buildings’ indoor and outdoor water use, with a requirement for moisture-sensing irrigation systems for larger landscape projects and mandatory inspections of energy systems (e.g., heat furnace, air conditioner and mechanical equipment) for nonresidential buildings over 10,000 square feet to ensure that all are working at their maximum capacity and according to their design efficiencies. The California Air Resources Board estimates that the mandatory provisions will reduce greenhouse gas emissions (CO2 equivalent) by 3 million metric tons equivalent in 2020.

Upon passing state building inspection, California’s property owners will have the ability to label their facilities as CALGREEN compliant without using additional costly third-party certification programs.

Note: Adherence to the California Green Building Standards Code is voluntary until Jan 1, 2010.

## OSHA RFI Developing Standard on Infection Control May 6 2010

"Amy Mulonas-MSIPC" <infectioncontrol@comcast.net> 05/11/2010 9:42 AM

Dear Members: On May 6 OSHA published their Request For Information on whether they should develop a standard or guideline on occupational exposure to infectious diseases in health care settings. OSHA had announced this last December as an addition to their 2010 agenda published this past March.

OSHA is considering what measures to take, including rulemaking or guidelines, to protect workers against infectious diseases. The agency will ask for information on the facilities and tasks that could expose workers to risk, infection control programs, control methodologies used by facilities, medical surveillance programs, training, and possible economic impacts of a standard on large and small businesses. Comments on the request will be due Aug. 4. Infection control measures might be necessary in workplaces including health care, emergency response, correctional facilities, homeless shelters, drug treatment programs, and others, the agency said. OSHA also will ask whether it should focus its deliberations on droplet and airborne transmission of diseases only, or also include contact transmissible diseases.

The RFI is appended along with a summary from BNA—the actual Federal Register site is: <http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=23847>

APIC, SHEA and AHA will be developing comment and I'm working with all 3 groups. We will keep you posted as it develops but thought you should be aware

Advocacy Chair, Judene Bartley MS, MPH, CIC; VP Epidemiology Consulting Services Inc; 17094 Dunblaine; Beverly Hills MI 48025 Ph 248-646-4785 Fax 248-646-3518 Cell - 248-225-6488 [jbartley@ameritech.net](mailto:jbartley@ameritech.net)

**Editor's note: For further information, MISHE members can read David LaHoda's blog posted April 27, 2010 on the HC Pro OSHA Healthcare Advisor website. See <http://blogs.hcpro.com/osha/author/dlahoda/page/5/> .**