

**Washington State
Department of Health**

Workshop 2

Review Comments on Proposals to
Modify Rules

Chapter 246-320 WAC
(Construction Standards only)

March 21, 2024

Proposal 003:

Submitter: Susan Upton

Hospital Book Section: 2.1-8.4.2.5

Proposal: Revise text as follows:

Heated potable water distribution systems

(1) Facilities shall develop a Water Management Plan that is risk based and includes provisions for controlling Legionella bacteria and other opportunistic waterborne pathogens.

~~(1)~~ (2) Provisions based on a risk management plan shall be included in the heated potable water system to limit the amount of Legionella bacteria and other opportunistic waterborne pathogens.

Statement of Problem and Substantiation: Clarify language needed to clearly state that a Facility Water Management Plan for Legionella Risk Management is a requirement; the existing language is tangentially based on reference to the appendix. This is required per CMS QSO-17-30 revised 07.06.2018 stating the Healthcare Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water.

There have been a number of incidents with waterborne pathogen outbreaks in Washington State Healthcare facilities and this requirement for facilities to develop and adhere to a Water Management Plan helps reduce the risk for Legionella and other pathogens in their water systems.

Appendix A2.1-8.4.2.5 Legionella Risk Management for Building Water Systems reference to CDC Guidelines for Environmental Infection Control in Health-Care Facilities, ANSI/ASHRAE Standard 188B: Legionellosis: and ASHRAE Guide 12: Minimizing the Risk of Legionellosis Associated with Building Water Systems.

Cost Impacts: None, CDC already requires hospitals to have a Water Management Plan.

Benefits: Clarified requirement; to ensure that design of hot water system has been integrated with the facility's WMP for continued operation and maintenance.

Comment on Proposal 03:

Submitter: Amy McCargar-Davis, MultiCare Health Systems

Section: Hospital Book Section: 2.1-8.4.2.5

Position: Expressing concerns only at this time

State of Problem and Substantiation for Comment: We have concerns around when, in the project life cycle, the water management plans would be required to be submitted to CRS. Often,

at the start of the project, it is not possible to have all the location-specific documentation complete for operational go-live. These are developed as construction gets closer to the end and we have operational stakeholders onboard who will be working in the new space.

Cost Impacts: This change will increase construction costs. The cost would vary.

Benefits: It would be beneficial to ensure water management plans could be submitted as they are developed during the construction process.

Proposal 004:

Submitter: Susan Upton

Hospital Book Section: 1.2-8 Commissioning

Proposal: Add new section as follows:

1.2-8.1 On projects involving installation of new or modification to existing physical environment elements critical to patient care and safety or facility energy use, at minimum the following systems shall be commissioned:

1.28.1.1 HVAC

1.2-8.12 Automatic temperature control

1.2-8.1.3 Domestic hot water

1.2-8.1.4 Fire alarm and fire protection systems (integration with other systems)

1.2-8.1.5 Essential electrical power systems

1.2-8.1.6 Security systems

1.2-8.1.7 Telecommunication systems

1.2-8.1.8 Wireless communication systems

Statement of Problem and Substantiation:

Telecommunication systems and wireless communication systems are fundamental systems for patient safety and should be commissioned to ensure reliability of system. Hospital requirements should not be less than the Outpatient requirements.

Cost Impacts: Minimal

Benefits: Improved patient safety

Comment on Proposal 04:

Submitter: Amy McCargar-Davis, MultiCare Health Systems

Section: Hospital Book Section: 1.2-8.1

Position: Revise text as follow:

1.2-8.1 On projects involving installation of new or modification to existing physical environment elements critical to patient care and safety or facility energy use, at minimum the following systems shall be commissioned:

1.28.1.1 HVAC

1.2-8.12 Automatic temperature control

1.2-8.1.3 Domestic hot water

1.2-8.1.4 Fire alarm and fire protection systems (integration with other systems)

1.2-8.1.5 Essential electrical power systems

1.2-8.1.6 Security systems

~~1.2-8.1.7 Telecommunication systems~~

~~1.2-8.1.8 Wireless communication systems~~

State of Problem and Substantiation for Comment: Adding telecom and wireless systems to commissioning requirements will add costs to construction projects for all scopes of work done on telecom and wireless communication systems.

Cost Impacts: This change will increase construction cost. The cost will vary depending on the project.

Benefits: We are concerned with the amount of cost increase the inclusion of Telecommunication systems and Wireless communication systems to this section.

Proposal 005:

Submitter: John Williams

Section: ASHE 170 – Section 6.1.2.3

Proposal: Add new section as follows:

6.1.2.3

Systems that provide heating whose source is dependent on variables outside of the facilities direct control shall provide a redundant heating source to provide the capability of maintaining the internal temperatures listed in Table 7-1. Examples of these types of systems include but are not limited to solar heating, heat pumps, geothermal heat, and variable refrigerant flow systems.

Exception: The facility or designer can demonstrate through independent engineering analysis and commissioning that the system is capable of maintaining facility temperature that support the facility operational plan. This includes continuity of operations, continuous operation of water-based systems and equipment, and patient care and comfort.

Statement of Problem and Substantiation:

Some of the new energy efficient HVAC systems are dependent on environmental factors – outside air temperature, sunlight, etc. The manufacturers of these system are developing more powerful and effective systems which may or may not meet the operational needs of a healthcare facility. The codes and standards have not adequately addressed these new systems and warrant some functional consideration. Since the effectiveness of these system depend on a factor that is out of the facility’s control, we believe that some level of redundancy should be required to maintain reasonable operation.

This proposal provides that redundancy only for those facilities that choose to use these systems. It does not specific the method of redundancy (electric reheat, hydronic, etc.) it only requires that the redundant system maintains temps inside of the facility. An exception is allowed to pursue an alternate path, and it provides some validation that the system will perform.

This addresses a gap in the code, and will allow CRS to prevent design that puts facilities in jeopardy. This would apply to both Hospital and Outpatient Books which include ASHE 170.

Cost Impacts: We estimate approximately \$6.50 per square foot cost increase to those facilities that choose these systems.

Benefits: Hospitals will be more resilient and maintain continuous operations longer.

Comment on Proposal 05:

Submitter: Teddi McGuire, Providence

Section: Section: ASHRAE 170 - 6.1.2.3

Position: Expressing concerns only at this time

State of Problem and Substantiation for Comment: Providence has concerns with this proposal and agree with comments at the public workshop that mechanical engineers should be part of this conversation. Through other regulation, the state is currently pushing building owners to go one direction with energy projects and these new (and needed) technologies are costly. To then back track and require us to have redundant systems increases that cost, and negates the direction the state wants building owners to go in. We want to do the right thing for our energy footprint, but may not choose to go with certain projects because while we want to choose the Cadillac-version of the project, we may opt for something lower than that because we also have to budget for the backup.

Cost Impacts: Not provided.

Benefits: Not provided.

Proposal 006:

Submitter: Teddy McGuire

Section: WAC 246-320-505(2)(1)

Proposal: Add new section as follows:

(a) Preconstruction. Request and attend a presubmission conference for projects with a construction value of five hundred two hundred fifty thousand dollars or more. The presubmission conference shall be scheduled to occur for the review of construction documents that are no less than fifty percent complete.

Statement of Problem and Substantiation:

In today's market conditions, \$250,000 is not a large project. Due to current difficulties with staffing and scheduling meetings with DOH, we are wondering whether this is an achievable target for DOH. This dollar amount could result in many projects requesting a meeting and any delays in scheduling and consequent approval from DOH which could lead to delays in the construction timeline and potential cost impacts.

\$500,000 is better threshold for projects with potential complexity and would require an upfront discussion.

Cost Impacts:

Benefits:

Raising the threshold would not impact construction costs of a project. Delays in scheduling the review due to abundance of requests could potentially have an impact on costs.

Comments on Proposal 06:

Submitter: Amy McCargar-Davis, MultiCare Health Systems

Section: WAC 246-320-505(2)(1)

Position: We support this proposal

State of Problem and Substantiation for Comment: We support this proposal.

Cost Impacts: This change will not increase construction costs. Operating cost impacts: n/a

Benefits: Adopting this proposal could decrease the number of projects that need to be taken through a pre-submission conference.

Proposal 007:

Submitter: Lara Macklin

Hospital Book Section: 2.1-7.2.3.2

Proposal: Revise text as follows:

2.1-7.2.3.2 Walls and wall protection

(1) Wall finishes

(d) Wall finishes shall be impact resistant when there is potential for equipment or furniture to cause damage over time

(i) corridors

(ii) exam rooms

(iii) patient rooms in family area

(iv) team rooms

(v) waiting rooms

(vi) public bathrooms

Statement of Problem and Substantiation:

Too often the finishes are not fully thought out due to first time costs and budget constraints. Many times this only leads to more maintenance as soon as 6 months after the project is completed. The addition of wall protection in corridors, anywhere equipment/carts are staged, and even some public areas like bathrooms, can make long term maintenance easier.

Cost Impacts: Depends on the amount and size of the project

Benefits: The potential benefit that this allows is significant long term cost savings, FTE needs for repairs

Comment on Proposal 07:

Submitter: Amy McCargar-Davis, MultiCare Health Systems

Section: Hospital Book Section: 2.1-7.2.3.2

Position: Revised test as follows:

Appendix 2.1-7.2.3.2 Walls and wall protection

(1) Wall finishes

(d) Wall finishes shall be impact resistant when there is potential for equipment or furniture to cause damage over time

(i) corridors

(ii) exam rooms

(iii) patient rooms in family area

(iv) team rooms

(v) waiting rooms

(vi) public bathrooms

State of Problem and Substantiation for Comment: We propose to remove this proposal entirely or to move this section to the Appendix so the proposal will be a recommendation, not a requirement. The proposal as it stands would add significant costs to projects. The proposed criteria appears to include protection for most walls in healthcare construction projects.

Cost Impacts: This change will increase construction costs. The cost impact per square foot would vary depending on the project. Operating cost impact would vary depending on the project.

Benefit: Removing this proposal would allow hospitals to determine the need for wall protection specific to each project and allow hospitals to control costs.