Impact of the Supreme Court’s Ruling on Hospital Design and Construction

AIA AAH Healthcare Reform Webinar
Presented by: Thornton Kirby, J.D.
President & CEO
South Carolina Hospital Association
November 15, 2012
Well, now we know.
Repeal is a long shot.
The debate isn’t over.
It’s the market, stupid.

The Affordable Care Act is not the source of reform...it’s the product of a market demanding change. Repeal it, and the pressure to change will not dissipate.
UNCERTAINTY AHEAD
Has health care ever been so political?

- America’s health care system is no stranger to politics
- Since WWII, health care policy in America has been *inherently* political
- There’s no reason to think an election will de-politicize the politics of health care, certainly not when tax dollars are funding half of all health expenditures
America’s health care system is no stranger to politics
1940s: employer-sponsored health care
1960s: government-sponsored health care

To provide coverage for the elderly as well as poor women and children, Congress enacted Medicare & Medicaid in the mid-1960s.
1980s: health care for all

The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 requires hospitals to screen and stabilize (treat) every patient who comes to the hospital ED seeking care, regardless of the patient’s ability to pay and regardless of what it costs the hospital to provide the care.
2006: Medicare expanded
Americans want three things...

1. Give me the best health care possible
2. Send the bill to someone else
3. Don't bother me about my behaviors
Every system is perfectly designed to get the results it gets.

– Paul Batalden,
Dartmouth Institute for Health Policy and Clinical Practice
problem #1: personal freedom has a price tag

- Smoking is the single most preventable cause of disease, disability, and death in the United States.
- Each year, an estimated 443,000 people die prematurely, and another 8.6 million live with a serious illness caused by smoking.
- Economic burden of tobacco use: more than $96 billion a year in medical costs.
Obesity Trends* Among U.S. Adults
BRFSS, 1985

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1986

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1987

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1988

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1989

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1990

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1991

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1992

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1993

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4’’ person)
Obesity Trends* Among U.S. Adults
BRFSS, 1994

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

No Data           <10%          10%–14%         15%–19%

Obesity Trends* Among U.S. Adults
BRFSS, 1995

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1996

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

No Data           <10%          10%–14%      15%–19%
Obesity Trends* Among U.S. Adults
BRFSS, 1997

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1998

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1999

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2000

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2001

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

(No Data)

<10%

10%–14%

15%–19%

20%–24%

≥25%
Obesity Trends* Among U.S. Adults
BRFSS, 2002

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2003

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2004

(*BMI ≥30, or ~30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2005

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2006

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2007

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2008

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2009

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2010

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1990, 2000, 2010
(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)
problem #2: somebody has to pay

RISE HEALTH INSURANCE COSTS STRAIN FAMILY AND EMPLOYER BUDGETS
Increases in Costs for Employer-Sponsored Insurance, 2003–2010

Average total premiums increased by 50 percent

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Premiums per Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>$9,249</td>
</tr>
<tr>
<td>2010</td>
<td>$13,871</td>
</tr>
</tbody>
</table>

The annual share of premiums that employees pay increased by 63 percent

<table>
<thead>
<tr>
<th>Year</th>
<th>Employee Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>$2,283</td>
</tr>
<tr>
<td>2010</td>
<td>$3,721</td>
</tr>
</tbody>
</table>

Average per-person deductibles increased by 98 percent

<table>
<thead>
<tr>
<th>Year</th>
<th>Deductible per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>$518</td>
</tr>
<tr>
<td>2010</td>
<td>$1,025</td>
</tr>
</tbody>
</table>

DESIGN: Suzanne Baker-Augustyn

I WANT YOUR TAXES
Paying Taxes is Patriotic!
National Health Expenditures
Total Annual Costs and Per Capita
1960 – 2010

Source: CMS National Health Expenditure Accounts
tell me again why this is my fault?
2010: health care reform
The affordable care act: nuts and bolts
key strategic objectives

- Coverage
- Insurance Reforms
- Delivery System Reforms
- Payment Reforms
- Transparency
- Health IT
U.S. Supreme Court

- 5-4 decision to uphold ACA
- Individual mandate stands...as a tax
- Medicaid expansion cannot be coerced; states must be allowed to opt out
The political question: what will states do?

- 27 states signed on later that year.
- 11 states joined in 1967.
- Most remaining states (southern) joined in 1970.
- Arizona last to join in 1982.
- Eventually all states participated in basic program and SCHIP (enacted in 1997).
some likely state options

- Red states “opt-out”
- Red states make noise... but then take the money
- Red states put some in Medicaid... punt rest to the exchange
- States go in... on their own terms
Ten states that will benefit the most

The number of uninsured adults earning less than 133 percent of the poverty line is expected to decrease by:

<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>% Reduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Kentucky</td>
<td>57.1%</td>
</tr>
<tr>
<td>2</td>
<td>Oregon</td>
<td>56.7%</td>
</tr>
<tr>
<td>3</td>
<td>West Virginia</td>
<td>56.7%</td>
</tr>
<tr>
<td>4</td>
<td>South Carolina</td>
<td>56.4%</td>
</tr>
<tr>
<td>5</td>
<td>Mississippi</td>
<td>54.9%</td>
</tr>
<tr>
<td>6</td>
<td>Nebraska</td>
<td>53.9%</td>
</tr>
<tr>
<td>7</td>
<td>Idaho</td>
<td>53.9%</td>
</tr>
<tr>
<td>8</td>
<td>Alabama</td>
<td>53.2%</td>
</tr>
<tr>
<td>9</td>
<td>Oklahoma</td>
<td>53.1%</td>
</tr>
<tr>
<td>10</td>
<td>Wyoming</td>
<td>53.0%</td>
</tr>
</tbody>
</table>

Ten states that will benefit the least

<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>% Reduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>Iowa</td>
<td>44.1%</td>
</tr>
<tr>
<td>42</td>
<td>Tennessee</td>
<td>43.3%</td>
</tr>
<tr>
<td>43</td>
<td>Illinois</td>
<td>42.5%</td>
</tr>
<tr>
<td>44</td>
<td>California</td>
<td>41.5%</td>
</tr>
<tr>
<td>45</td>
<td>Pennsylvania</td>
<td>41.4%</td>
</tr>
<tr>
<td>46</td>
<td>Delaware</td>
<td>15.9%</td>
</tr>
<tr>
<td>47</td>
<td>New York</td>
<td>14.8%</td>
</tr>
<tr>
<td>48</td>
<td>Arizona</td>
<td>13.6%</td>
</tr>
<tr>
<td>49</td>
<td>Vermont</td>
<td>10.2%</td>
</tr>
<tr>
<td>50</td>
<td>Massachusetts</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

States that Obama won majority vote in 2008 presidential election
States that McCain won

Source: The Henry J. Kaiser Family Foundation, U.S. Department of Health and Human Services
The **operational** question: how should physicians and hospitals revise their business models?
implications for hospitals

- Achieve solid clinical alignment between hospital and physicians
- Deliver superior outcomes
- Reduce costs
- Develop integrated information systems
- Form strategic alliances
- Prepare for new payment models
implications for hospitals

- Achieve solid clinical alignment between hospital and physicians
- **Deliver superior outcomes**
- **Reduce costs**
- Develop integrated information systems
- Form strategic alliances
- Prepare for new payment models
Tulane Medical Center alerts patients after medical gear improperly sterilized

Published: Thursday, March 10, 2011, 9:30 PM    Updated: Tuesday, March 15, 2011, 3:36 PM

By Bill Barrow, The Times-Picayune

Tulane Medical Center has notified 360 patients that it failed to properly sanitize gastrointestinal scoping equipment used during seven weeks last fall, potentially exposing the group to various infectious diseases.

Dr. Robert Lynch, the hospital’s CEO, acknowledged the error in a Jan. 3 letter that invited affected patients to obtain free screening for hepatitis B, hepatitis C and HIV. The letter, however, characterized the chances of infection as “minimal to non-existent.”

Lynch cited a mistake in one of five steps in its sanitizing protocol and framed the tests as a way “to reassure patients whose procedures were impacted.”

State epidemiologist Dr. Raoult Ratard, who has conferred with Tulane officials

The Joint Commission
Monday: Wrong kidney removed from Methodist cancer patient

By MAURA LERNER and JOSEPHINE MARCOTTY / StarTribune
startribune.com
updated 10:30 p.m. CT, Tues., March. 18, 2008

In what officials are calling a "tragic medical error," a surgical team removed the wrong kidney from a patient with kidney cancer last week at Methodist Hospital in St. Louis Park, the hospital disclosed Monday.

Officials said the error occurred weeks before the surgery, when the kidney on the wrong side was identified on the patient's medical charts as cancerous. The patient, who was not identified, was left with the cancerous kidney when the healthy one was removed.
'You're taking out wrong kidney, surgeon was told'

by CLARE KITCHEN, Daily Mail

A surgeon accused of killing a patient by taking out the wrong kidney was warned he was making a mistake by a medical student watching the operation, a court heard yesterday.

Dr Mahesh Goel dismissed the concerns of student Victoria Fern and pressed on with the surgery, it was said.

Goel and consultant urologist John Roberts are accused of manslaughter over the 'appalling error' which left 70-year-old Graham Reeves with one diseased kidney.

The Korean War veteran died five weeks after the botched operation.

Roberts, 59, and Goel, 39, had shown a level of care far below that which is expected of competent surgeons, prosecutor Leighton Davies QC said.

'It was a drastic surgical error described by Mr Roberts himself in the aftermath as the worst thing he had done in his life,' said Mr Davies. 'He says it was an appalling error.'

Mr Reeves, who was single, was due to have his damaged right kidney removed. But the surgeons removed his left kidney and before the mistake was realised it was put in a jar of acidic sterilising agent.

'The right kidney was diseased for years and non-functioning,' Mr Davies told Cardiff Crown Court.

'The operation played a significant part in causing his death. It deserves to be condemned as gross negligence and therefore a crime.'
Current State of Quality

Routine safety processes fail routinely

- Hand hygiene
- Medication administration
- Patient identification
- Communication in transitions of care

Uncommon, preventable adverse events

- Surgery on wrong patient or body part
- Fires in ORs, retained foreign objects
- Infant abductions, inpatient suicides
“High reliability organizations” manage very serious hazards extremely well

- Commercial aviation, nuclear power

What do they all have in common?

- Highly effective process improvement
- Fully functional safety culture

Discover and fix unsafe conditions early

“Collective mindfulness”
How Safe are US Airlines?

1990-2001
• 129 deaths per year
• 9.3 million flights per year
• Rate = 13.9 deaths per million flights

2002-2010
• 18 deaths per year
• 10.6 million flights per year
• Rate = 1.74 deaths per million flights

= 87% ↓
Safety: Airlines vs. Health Care

- IOM “To Err is Human” estimate
  - 44,000-98,000 deaths in hospitals due to errors in care
  - 34.4 million hospitalizations per year
  - Rate = 1300-2800 deaths per million hospitalizations

- US Airlines: 2002-2010
  - Rate = 1.74 deaths per million flights

- Hospital care is 750-1600 times less safe
Implications for facility design

macro

micro
Macro level questions

- Where will we need new hospitals?
- **Will** we need any more hospitals?
- Will we need all the hospitals we have now?
- How many hospital beds will we need in the future?
- Should we move forward with the current project?
- Will funding be available?
Micro level questions

• What changes are needed in patient care environments?
• What materials will reduce the spread of infections?
• How can facility design help hospitals become highly reliable organizations?
• How can facility design increase patient satisfaction?
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