Restoring the Health of Medical Care Facilities

Recognizing State Building Codes as Meeting Federal Requirements

In 1965, "regular" gas cost 31 cents a gallon in the U.S. and the average price of a new home was $20,500. That was also the year legislation creating the Medicare and Medicaid programs was passed by Congress and signed into law by President Lyndon Johnson.

In the course of developing these programs, it was agreed that health care facilities providing treatment to be reimbursed by the federal government should be required to comply with adequate fire safety standards. Unlike today, however, with the *International Building Code* serving as the clear national standard, there was no single, comprehensive model code in use across the county.

To avoid the complexity of citing multiple building codes and standards, federal legislators applied the minimum requirements of the *Life Safety Code* (LSC) as the default condition for means of egress fire protection. At the same time, the Secretary of the U.S. Department of Health, Education and Welfare was given statutory authority to recognize fire and safety codes imposed by state law and thereby waive application of the LSC—an authority now held by the Secretary of the U.S. Department of Health and Human Services (HHS).

This waiver authority was an effort by Congress to avoid unnecessary and unproductive conflict between the limited scope of the LSC in health care facilities and more complex and comprehensive building codes applied locally to all types of buildings, including health care facilities. Yet in the more than four decades since, an effective means for demonstrating eligibility for this waiver has not been established, nor has a single state waiver request been approved.

President Johnson was able to use the momentum gained during the 1964 election to engineer passage of the landmark Medicare and Medicaid legislation, which revolutionized the U.S. health care industry. And now, with a new president just elected, it is a virtual certainty that rising costs and increased demand

for better access will prompt renewed efforts to transform health care in ways that will have profound impacts on the building safety community. Against this backdrop, the question of whether the incoming administration will recognize the significant changes that have occurred at the state and local levels due to widespread use of a single set of model building and fire safety codes is growing more critical by the day.

The Future Isn't What It Used to Be

The statistics tell a sobering story. According to the World Health Organization, while the U.S. ranks number 1 in the world in health care expenditures per capita, it ranks 37th among 191 nations in overall health care performance and 72nd in the level of health. And in a study released in May 2007 by The Commonwealth Fund, the U.S. ranked last among the six leading industrial nations in patient safety, patient-centered care, efficiency and equity.

A growing body of literature describes the link between a hospital's physical design and key safety and quality of care outcomes. A 1999 report by the Institute of Medicine, "To Err is Human: Building a Safer Health System," estimated that between 44,000 and 98,000 people die each year in the U.S. as a result of preventable adverse events, and hospitals are increasingly focused on designing facilities that enhance patient safety, improve the quality of service, boost workforce satisfaction and reduce the overall cost of care.

Hospital planners expect to spend nearly $250 billion on construction in the next decade—and perhaps as much as $60 billion annually by 2010—in what the American Institute of Architects calls one of the fastest-growing institutional construction categories. Aging facilities, demand for new technologies, increasing competition and changes in patient populations are all driving the push for the "hospitals of the future," according to the Healthcare Financial Management Association and GE Healthcare Financial Services "Construction Trends and Capital Implications" report issued earlier this year. The report also notes that more hospitals are going green, with energy-efficient facilities offering healthier environments for patients and staff and lowering utility costs by 20 to 50 percent.

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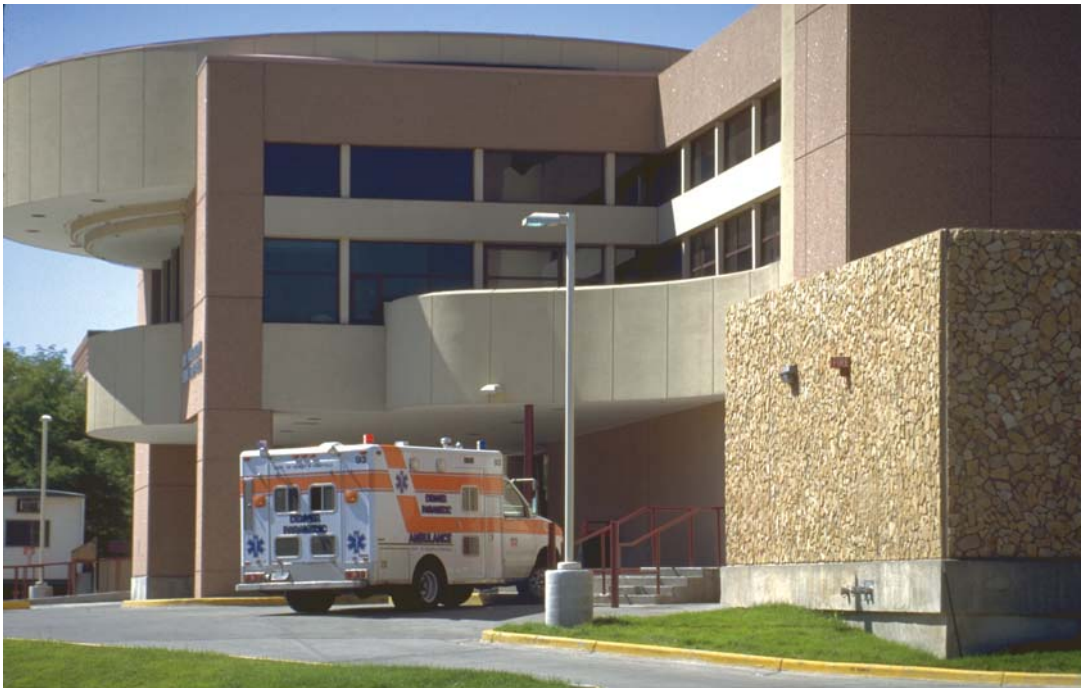

However, as architect Peter Bardwell recently noted, "the future isn't what it used to be," pointing to the five years it can take to plan, design and construct a hospital and the remarkable—and often unforeseeable—changes that can occur during that period. Amid these unprecedented challenges, the building safety community clearly has a pivotal role to play, and successful navigation of the road ahead will require a new kind of partnership among health care providers, government regulators, and code and safety officials to improve consistency in the application and enforcement of building codes, regulations and laws for all health care facilities.

How Times Have Changed

As had been the case since the early 1900s, three model code development organizations served the nation in 1965, providing similar but regionally distinct building and fire codes. Over time, the emergence of a global marketplace and continuing technological advances in construction meant the country would be better served by a single set of coordinated codes without regional limitations but with enough flexibility to address local needs. When those three legacy groups consolidated in 1994, the International Code Council was born.

Today, one or more of ICC's *International Codes* have been adopted at the state or local level in all fifty states and the District of Columbia, and numerous federal agencies, including the General Services Administration, the Department of Defense and the Architect of the Capitol, have implemented them, as have Puerto Rico and the U.S. Virgin Islands. Buildings of every stripe are governed by the I-Codes, including schools, homes, offices, warehouses, malls, military housing, embassies and—of course—health care facilities.

The adoption and enforcement of model building codes have long driven improved safety in health care facilities. Thirty years ago, for example, Ohio was the first state to retroactively require sprinkler systems in nursing homes—and although a number of other states subsequently followed suit, it was not until June of this year that the Centers for Medicare and Medicaid Services (CMS), which administers the programs for HHS, finally issued a rule that will eventually require all long-term care facilities that serve Medicare and Medicaid beneficiaries to be sprinklered. Similarly, the I-Codes were the first to provide for installation of alcohol-based hand rubs in institutional occupancy corridors for infection control.

These and other measures have literally meant the difference between life and death, and they would not have happened without the leadership of model code developers and the actions of jurisdictions. From energy efficiency and interoperability to sustainability and accessibility, the Code Council continues to support the

most up-to-date and cost-effective rules to achieve the highest levels of patient safety. But the failure by CMS to accept the I-Codes as meeting the statutory requirements for fire safety threatens this spirit of innovation, with responsible state and local jurisdictions unable to fully exercise their obligations to protect their constituents in hospitals and nursing homes in the same way they enforce other public health and safety requirements.

Between a Rock and a Hard Place

State and local jurisdictions find themselves today in an untenable position. Since the inception of the Medicare and Medicaid programs, there has been no congressional mandate requiring use of the LSC for participating facilities. Rather, the goal of the 1965 Social Security Act that created the programs was to protect patients by ensuring that an adequate standard of safety was always in effect. The *International Codes* indisputably meet that goal.

Yet in order to be eligible for financial reimbursement from the Medicare and Medicaid programs—which is critically important to health care providers—communities are often directly or indirectly required to comply both with their adopted building code and CMS requirements, even when those dual requirements burden the health care system and are not in the best interests of patient safety or consistent with Congress' original intent.

This September, CMS issued a memo to state survey agency directors regarding use of state fire and safety codes in lieu of the LSC to qualify health care providers under the Medicare and Medicaid programs. After first noting that no state currently has approval to use its code for federal certification purposes, the memo goes on to outline the process for securing this approval and the considerable costs and challenges such an effort would entail. Under terms outlined in the memo, even after gaining state code recognition a new application would have to be submitted upon any change to the LSC or the state's own code. Furthermore, recognized states would not receive federal funding to conduct life safety audits.

In addition to the establishment of bureaucratic hurdles, the memo is perhaps most notable for what it does not include. Nowhere does it recognize the fundamental reality understood by all members of the building safety community that the I-Codes have standing in all fifty states as the consensus requirements for adequate building and fire safety. As such, it seems likely the memo will not help eliminate any of the conflicts and inconsistencies that currently delay projects, increase costs and threaten patient safety by preventing states from ensuring that health care facilities are built to the same exacting standards as all other buildings.

The Code Council is working on behalf of its membership to resolve this issue, but with CMS recently signaling its intention to apply the LSC to every health care provider covered under the Medicare and Medicaid programs—and perhaps to every school, medical office building and other occupancy where there are health services reimbursed by the programs—time may be growing short. ◆

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