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MEMORANDUM

May 21, 1991

TO: Susan Stuntz

FROM: Martha Rinker

SUBJECT: Hospital Strategy Plan

Attached is the proposed "Hospital Strategy Plan." This proposal is in response to the Joint Commission on the Accreditation of Healthcare Organizations (JCAH) requirement that hospitals enforce smoking bans for maintenance of their accreditation.

The American Hospital Association (AHA) is planning to launch a public relations campaign around the new JCAH requirement using materials -- apparently prepared some years ago -- that carry the slogan, "Smoking and hospitals are a bad match."

The objective of our plan is to encourage the AHA to repeal its public relations campaign and to focus the AHA and the JCAH on the broader issue of IAQ.

The plan proposes the inclusion of hospital IAQ concerns into TI's current IAQ activities; including the introduction of hospital air quality issues into HBI media tours and IAQ articles and using the BCIA to encourage hospitals join in the buildings systems approach to IAQ movement.

New strategies include the identification of health-care economists and attorneys and encouraging them to write articles on the costs of cross-infections and the liability problems hospitals face with poor IAQ.

There is no project budget at this time. The Strategy I activities would be add-ons to our current IAQ activities and could be accomplished this year. The other strategies, work by health-care economists and attorneys, will be costly. But if the plan is approved, these tactics could become a part of the 1992 Public Smoking plan. Identifying the experts and laying the ground work for the studies and articles would be done in 1991. Funding for the work would be in next year's budget.

The plan has been reviewed by Covington & Burling and Shook, Hardy & Bacon.

I recommend that we go forward with this plan. The hospital smoking bans are of particular interest to one of our member companies, and the goals and tactics, especially in Strategy I, are achievable.

Attachment

cc: Marty Gleason

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Hospital Strategy Plan

Background and Assumptions

Beginning in January 1992, the Joint Commission on the Accreditation of Healthcare Organizations (JCAH) will require that hospitals "disseminate and enforce" smoking bans.

Hospitals must receive JCAH accreditation to receive Medicare, Medicaid and most private health insurance payments. About 5,400 of 6,800 U.S. hospitals are accredited.

The chances of reversing the JCAH decision are negligible. It may be argued that, as a practical matter, the new rule will have little effect, because many hospitals already ban smoking. We know of no larger plans for indoor air quality-related policies for hospitals.

The American Hospital Association (AHA) is taking advantage of the new requirement to launch a public relations campaign -- further adding to the promotion and legitimization of smoking bans. The AHA materials, which apparently were prepared several years ago but never promoted, carry the slogan, "Smoking and hospitals are a bad match." The AHA is distributing its public relations kit to member hospitals, and spreading the word through state hospital associations. It is anticipated that the campaign will begin slowly and peak in the fourth quarter of 1991, just before the rule goes into effect.

Experts on indoor air quality (IAQ) acknowledge that hospitals may pose a serious IAQ threat. Not only are patients exceptionally vulnerable to disease, but the air in hospitals is likely to contain unusual amounts of bacteria, fungus and other disease-causing mechanisms.

Hospitals are required to maintain special air filtration units in some areas, such as operating suites and units serving burn patients and others especially vulnerable to infections. However, much of the space in hospitals is served by air handling systems not much more complicated or better maintained than those found in office buildings.

Hospitals are acutely aware of the problem of cross-infections, [illegible] discuss the issue. Their three greatest concerns are:

1. Litigation, for example, patients suffering unnecessarily from diseases caught while in the hospital. Patients'-rights groups, many of which are sustained by unions, may be interested in joining the debate on indoor air quality.

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2. Additional criticism and regulation of costs. Cross-infections no doubt add to the time some patients stay in hospitals. Length of stay is a major element of hospital costs.

3. Worker safety. Hospital unions are militant and, in some places, growing. The American Hospital Association PR program focuses on union members among other audiences.

Excise taxes earmarked for health care are becoming an increasingly vulnerable option in the attempt to offset the uncontrolled rise in health-care costs.

Objective

To encourage the AHA to repeal its public relations campaign on hospital smoking bans and attempt to focus the AHA and the JCAH on the broader issue of IAQ.

Strategies, Goals and Tactics

Strategy I: Argue that the AHA campaign seeks to divert attention from the serious IAQ situation in hospitals, which contributes to worker health problems and cross-infection problems.

Goals and Tactics:

1. Introduce the discussion of sick hospital buildings in HBI media tours. Focus attention on cities with AHA board members.

2. Encourage IAQ experts to write and publish articles on hospital air quality. Assist in placing articles in hometown publications of AHA board members and of Members of Congress who sit on key health subcommittees.

3. Encourage hospitals or hospital associations to join the Business Council on Indoor Air. BCIA is already considering asking hospitals to join as associate members. Many of BCIA's current members provide products or services to hospitals.

4. Work through BCIA to encourage JCAH -- or other appropriate rule-making bodies with which hospitals must comply -- to adopt ASHRAE's indoor air quality standard.

5. Encourage IAQ experts to debate hospital officials on the subject of indoor air quality in cities with AHA board members.

6. Continue to offer IAQ technical assistance to hospital workers through the Labor Management Committee.

7. Identify patients'-rights groups, such as the Public Citizen Health Research Group, that might be encouraged to join the debate in demanding higher quality indoor air in hospitals.

Strategy II: Point out how the problem of cross-infections brought on by poor IAQ adds to hospital costs, which are already out of control.

Goals and Tactics:

1. Identify health-care economists and encourage them to write articles and op-eds on the impact of cross-infections on hospital costs. Assist in placing articles in publications serving hometowns of AHA board members and key Members serving on health-care subcommittees.

2. Create an information packet on the issue of indoor air quality in hospitals and the impact of cross-infections on hospital costs for use by lobbyists to help offset new taxes earmarked for health-care services.

Strategy III: Explore the liability of hospitals whose poor IAQ contributes to high rates of cross-infection.

Goals and Tactics:

Encourage health-care attorneys, who are in the process of being identified, to research and write papers on liability problems hospitals face in this area. Distribute these papers to the trustees of liability insurance companies for state hospital associations. Also distribute these papers to appropriate patients'-rights groups.

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