



Hospital Emergency Preparedness and Response

Background

Hospitals play a key role in the nation's emergency preparedness and response as part of America's health care infrastructure. As part of this standby role to communities, hospitals are pivotal to disaster-response activities, whether they are rural, critical access hospitals (CAHs) or Level 1 trauma centers. In the past two years alone, hospitals in New York, New Jersey, Massachusetts, Oklahoma, Texas and many other locations have activated their emergency plans to save lives and care for the seriously injured during disaster situations.

Emergency preparedness requires a significant investment in staff and resources. It requires constant staffing of the emergency department, laboratories, the radiology department, pharmacy, surgical services, general and intensive care units, labor and delivery and other areas. Many Americans still lack health care coverage, increasing the likelihood they will delay seeking care until it is an emergency. But hospitals must care for all patients who seek emergency care, regardless of their ability to pay. This means that it costs far more for hospitals to provide services than other settings of care.

In times of disaster, communities look to hospitals not only to care for the ill and injured, but also to provide food and shelter and help coordinate recovery. Being ready for any possible scenario, including natural disasters, biological warfare, terrorism and radiological and nuclear events, means hospitals must invest in communications and emergency power systems, purchase personal protective gear, build decontamination units and stockpile medical supplies. Hospitals must be part of comprehensive community disaster plans, training, drills and surveillance systems. These are formidable investments at a time when government funding for these services is being reduced. But it is this level of constant readiness and responsiveness that defines hospitals and benefits communities.

AHA View

Preparedness is not a one-time investment. Rather, it is a dynamic process that changes over time. Hospitals and health systems learn from each emergency situation, and it is crucial that they have the appropriate funding to adopt best practices, incorporate new technology into their emergency readiness plans and have the ability to care for their communities when a disaster or terrorist attack occurs. Greater public expectations about hospitals' role in disaster preparedness and response also have led to increased federal, state and local oversight and regulation, and more comprehensive accreditation and other standards, all of which increase the costs of preparedness.

Sustained Funding for Hospital Preparedness. The Hospital Preparedness Program (HPP), the primary federal funding program for hospital emergency preparedness, has provided critical resources since 2002 to improve health care surge capacity and hospital preparedness for a wide range of emergencies. The HPP has supported greatly enhanced planning and response, facilitated the integration of public and private sector medical planning to increase the preparedness, response and surge capacity of hospitals, and has led to improvements in

state and local infrastructures that help hospitals and health systems prepare for public health emergencies. These investments have contributed to saving lives during many events, such as the Joplin tornado and the Boston Marathon bombing.

However, authorized funding levels and annual appropriations for the HPP have significantly declined since the program began. Congressionally authorized funding and appropriations for the HPP was \$515 million per year in the early years of the program. The Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA) reduced authorized funding for the HPP to \$374.7 million per year for fiscal years (FYs) 2014 through 2018. However, for FY 2014, Congress appropriated only \$255 million for the HPP – that’s more than a 50 percent reduction from prior years. Similarly, the president’s FY 2015 budget proposal recommends only \$255 million for the HPP.

While the HPP funding is not the only way in which hospitals cover the costs of providing 24/7 emergency coverage and building the infrastructure needed to be ready for disasters, the cuts symbolize erosion in financial support for disaster preparedness at a time when the need for these services is growing. In addition, the HPP funding cuts undermine the Department of Health and Human Services’ (HHS) ambitious emergency preparedness agenda to advance all-hazards preparedness and national health security by building an effective medical surge response through the development of robust, hospital-based systems and strong, resilient and effective regional health care coalitions. This development will be difficult to achieve if HPP funding is reduced.

To help hospitals and health systems develop, update and sustain their emergency preparedness and response capabilities, the AHA urges the Obama administration and Congress to increase the FY 2015 appropriation for the HPP to \$374.7 million, consistent with the amount authorized in PAHPRA.

CMS Proposed Emergency Preparedness Rule. The Centers for Medicare & Medicaid Services (CMS) in December 2013 issued a proposed rule that would establish emergency preparedness conditions of participation (CoPs) that hospitals, CAHs and 15 other provider and supplier groups would have to meet to participate in the Medicare and Medicaid programs. CMS has formulated its proposed regulations in four key areas: risk assessment and planning based on an “all hazards” approach; policies and procedures based on risk assessment and planning; a communications plan; and training and testing. In addition, inpatient providers, including hospitals, long-term care facilities and CAHs, would be required to comply with emergency and standby power systems’ requirements.

The AHA supports CMS’s goal for Medicare providers and suppliers to have comprehensive emergency preparedness plans and generally believes that the agency has chosen the correct framework for the proposed CoPs. In the AHA’s formal comments, we urge CMS to make sure its requirements enhance readiness

without adding confusion or creating additional administrative burden. The top priority of hospitals during a disaster is to ensure that patients are safe and can receive the services they need. This is why many hospitals already meet existing emergency operations standards promulgated by The Joint Commission (TJC), National Fire Protection Association and the HPP, as well as state and local governments.

Therefore, we encourage CMS to consider five principles, detailed below, as it finalizes its proposed rule and develops interpretive guidance for the new regulations.

1. **Align policies with existing and current standards** – CMS standards should be aligned as much as possible with existing standards, laws and regulations to avoid conflict and confusion, and the standards should be evaluated and updated periodically to reflect new knowledge and advances in technology.
2. **Define leadership roles for community planning** – CMS should recognize that local emergency management and public health authorities are the best-placed entities to coordinate their communities' disaster preparedness and response, collaborating with hospitals as instrumental partners in this effort.
3. **Accept an integrated approach to emergency planning** – Integrated health systems should have the option to maintain one coordinated emergency plan in cases when a single plan improves preparedness.
4. **Collaborate to develop interpretive guidance** – CMS should use a transparent process working with stakeholders to develop interpretive guidance.
5. **Balance implementation and compliance with education** – State surveyors should assess compliance as appropriate and also realize that they can play an important educational role in helping providers meet and exceed the standards.

The AHA also is concerned that CMS has underestimated the cost and time needed to implement its proposed changes. CMS should revise the cost estimates and adjust the final rule provisions and timetables as appropriate to reflect the time and resources required.

Further, the AHA believes that the agency's proposed one-year timeframe will likely be too short for many hospitals, other providers and suppliers to come into compliance once the final rule is issued. For TJC-accredited hospitals, we believe that two years should be sufficient. In cases in which hospitals must make significant structural changes, however, the affected hospitals should be able to articulate to CMS a reasonable period of time to comply. Other providers and suppliers, including CAHs, home health agencies and hospices, also may need additional time.