Can Health Care Providers Afford to Be Ready for Disaster? (NYT)

MORE than 200 people died in hospitals and nursing homes in Louisiana after Hurricane Katrina in 2005, leading to widespread agreement that health care preparedness in the United States needed dramatic improvement. One hospital, Memorial Medical Center, was so undone that two desperate doctors later said that they hastened the deaths of patients who had waited days in the heat for rescue.

The chaotic evacuations of more than 6,400 hospital and nursing-home patients in New York City after Hurricane Sandy in 2012 — where some were separated from their records and untraceable by their families for weeks — reinforced concern about the readiness of health care providers during emergencies.

Despite repeated calls for change, however, and billions of dollars in disaster-related costs for health care providers, federal rules do not require that critical medical institutions make even minimal preparations for major emergencies, from hurricanes, earthquakes and tornadoes to bioterrorist attacks and infectious epidemics such as Ebola and Zika.

“We’ve had way too many circumstances where the results are catastrophic,” said Karl Schmitt, a former division chief for public health preparedness in Illinois and founder of the consulting firm bParati. “Preparedness doesn’t put heads in beds, and if it doesn’t put heads in beds, it doesn’t bring in revenue, so it’s not going to get the C.E.O.’s attention.”

That may soon change. Industry experts are awaiting release of a federal rule that would make emergency preparedness a condition for a wide range of health care institutions to participate in the Medicare and Medicaid programs. More than 68,000 providers would potentially be affected, including hospitals, kidney dialysis centers, psychiatric treatment facilities, home health agencies and organ transplant procurement organizations. Among other steps, providers would be required to conduct regular disaster drills, have plans for maintaining services during power failures and create systems to track and care for displaced patients.

Those requirements were under development as early as 2007, during the Bush years. The government finally made public a draft of the proposed rule in 2013 **[LINKED AND ATTACHED]**, describing it as an “urgent public health issue” and inviting public comments. But it still has not been finalized. As often occurs with disaster preparedness itself, other issues have taken precedence. “Preparedness of our hospitals rises to the fore each time a natural disaster (e.g., Hurricane Katrina) or significant pandemic (e.g., Ebola) occurs,” wrote Donna E. Shalala, a former Health and Human Services secretary, in prepared remarks for a Congressional hearing on combating biological threats on Friday. “We want to see more deliberate and systematic planning.”

The federal health official overseeing preparedness and response, Dr. Nicole Lurie, an assistant secretary at Health and Human Services, said the proposed rule could help build overall health system resilience and save lives. “Being ready and able to withstand disaster can benefit individual health care facilities and the local economy and helps the community as a whole recover faster.”

The proposed rule, however, appears stalled. Since Nov. 3, it has been parked at the Office of Management and Budget, undergoing a legally required review. A spokeswoman for the office said the 90-day review period had been extended.

Part of the reason for the yearslong wait may lie in the critical reaction to the proposal from health care groups, which argued that certain provisions, including testing backup power generators more frequently for longer periods (they have failed often in emergencies), were too costly and unnecessary.

“There was a lot of opposition to what they proposed,” said Robert Solomon, a division manager for building and life safety codes at the National Fire Protection Association, which developed its own disaster-emergency management standard and has urged the Centers for Medicare and Medicaid Services to defer to it.

In December, reviewers from the Office of Management and Budget discussed the rule with representatives of the American Health Care Association, which represents facilities that care for the elderly and disabled, and has challenged the cost estimates associated with the requirements.

Medicare’s calculations suggested a relatively modest impact: $8,000 on average for hospitals the year the rule takes effect and about $1,262 each year for skilled nursing facilities. But the association said that those figures were unrealistic because of factors like emergency overtime.

Others who commented on the proposal said they feared that the rules would be particularly burdensome for smaller facilities that have traditionally not been involved in emergency preparedness. “Each organization can

only do so much based on their resources," Mark Covall, president and chief executive of the National Association of Psychiatric Health Systems, said in an interview.

Ashley Thompson, a senior vice president at the American Hospital Association, said the group generally agreed with the proposal, but hoped Medicare would align its requirements with crisis preparedness standards developed by other bodies, including the Joint Commission, which accredits many American hospitals and other health institutions.

Mr. Schmitt said those resisting regulation were shortsighted. "It's saying, 'Look, if you want to care for the more vulnerable populations in America and you want to bill for these services, we're just saying meet some minimum standards.' "

But girding for emergencies often seems to fall off the map as a disaster recedes. More than 45 years after the Sylmar earthquake killed dozens at California hospitals, for example, more than 250 hospital buildings rated most at risk of collapsing and endangering the public have yet to be retrofitted, replaced or removed from service. "If I never have a disaster and you make me invest, say, $100,000 or $500,000 in preparedness, I've lost revenue," said Dr. David Marcozzi, an associate professor at the University of Maryland School of Medicine. "However, for the facility that is impacted and is able to continue treating patients, the return on investment is different. Tell me, how do you do a budget analysis on that?"

Dr. Marcozzi, a former director of the National Healthcare Preparedness Programs at Health and Human Services, recently left a position at Medicare, where he contributed expert advice to the group working on the rule. They were considering scaling back or revising it "to accommodate a lot of the stakeholders," he said.

Part of the solution, he added, could be to create incentives for providers demonstrating preparedness, like higher Medicare reimbursements, increased credit ratings and lower insurance premiums.

The rule has a statutory deadline of three years from proposal to publication, and if it is approved, much of its strength will depend on how it is interpreted and enforced. "If this has political will, which unfortunately it hasn't historically, it will get across the goal line," Dr. Marcozzi said. "If it doesn't, and other things encumber it, this will not get to final."