

# Lessons from the COVID-19 Pandemic: Planning for Disaster Preparedness and Emergency Management in Hospitals

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Although the COVID-19 pandemic is still active worldwide, health care industry leaders and regulators have already begun to think about how to implement post-pandemic changes to health care delivery based on lessons learned during the global emergency of the past year and a half. We have reported on some such post-pandemic changes to the health care industry in previous blog posts. For instance, some temporary solutions to challenges presented by COVID-19 are being made permanent due to their proven efficiency or effectiveness. The [expansion of telehealth](#) is a primary example of this. We have seen the Centers for Medicare and Medicaid Services (“CMS”), as well as state governors and legislators, expand and extend certain regulatory waivers that were initially designed as temporary solutions to allow for greater access to patient care during the pandemic, but that are becoming permanent fixtures due to their usefulness in innovative patient care delivery generally.

Other post-pandemic changes to the health care delivery landscape will be borne out of sheer necessity rather than innovation. Perhaps most importantly, we have learned that hospitals' pre-COVID emergency management and disaster preparedness plans were insufficient to handle the scale, intensity, and duration of a health disaster like COVID-19. At present, CMS requires that providers, including hospitals, develop emergency preparedness protocols, including policies, procedures, and communication plans, as a condition of participation in Medicare and Medicaid. CMS requires hospitals to develop an "all-hazards approach," which it [describes](#) as "an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies and a man-made emergency (or both) or natural disaster." In September 2019, CMS released [revised guidance](#) in the so-called "Burden Reduction Rule," which decreased requirements that hospitals had to follow in various areas, including emergency preparedness, to enable hospitals to deliver care "at the lowest possible cost." These changes decreased requirements for emergency planning, communication, training, and testing.

CMS's regulatory response to the post-pandemic realization that hospitals need more, not fewer, comprehensive emergency management and disaster preparedness plans remains to be seen. However, even as the threat of COVID-19 wanes, the threat of climate change, natural disasters, mass trauma events, and future pandemics still looms. At this critical time, when the challenges presented by the pandemic are still fresh in the minds of leaders who had to scramble to deliver care during a global disaster, regulators, hospital executives, and hospital management personnel must begin to think about how to create more comprehensive plans to better manage these health crises that may be on the horizon. Several critical features of the COVID-19 pandemic may serve as useful jumping off points to develop more comprehensive plans for future disasters:

1. **Shortages of Personnel, Medical Equipment, and PPE:** COVID-19 did not just impact one region of the country, or even the world, the way a mass casualty event might. Therefore, a typical strategy of calling on the typical resource network for hospitals – namely, other hospitals in neighboring states – for staffing, personal protective equipment ("PPE"), medical equipment (e.g., ventilators), and space reinforcements, did not work during the pandemic. All hospitals everywhere were strapped for resources.

Eventually, retired providers were called on to assist with unprecedented staffing shortages in late 2020 and 2021. Hospital executives must think through where these reinforcements must come from in the next health crisis, and how these resources can be called upon quickly and efficiently. Consideration should also be given to the ongoing possibility of having to allocate scarce life-saving resources, such as ventilators, in an ethical manner.

2. **Bed Shortages:** During the COVID-19 pandemic, overcrowding of hospitals led to unprecedented bed shortages. In part, this was due to the fact that hospitals were unable to discharge patients too sick to go home, but not sick enough to remain in the hospital. In March 2020, New York State required nursing homes to admit residents regardless of their COVID-19 status. This mandate was overturned in May 2020. As we reported in a [previous blog post](#), post-acute care facilities would then only admit patients without a negative COVID-19 test, leading to overcrowding of hospitals as patient discharges were delayed while waiting for test results. Hospital executives should plan for such overcrowding by maintaining plans for surge capacity and determining where patients will be redirected should overcrowding be as grave a concern as it was during this pandemic.
3. **Ongoing Uncertainty:** The COVID-19 pandemic was unique to many crises in that it was full of long-term uncertainty. Unlike a natural disaster or a mass trauma event, no one knew how long the pandemic would last, how the disease spread, or what protocols were best to reduce its transmission. As a result, hospitals struggled to develop protocols and communicate them across their workforces and to patients in a timely manner. In case of future health crises with similar degrees of uncertainty, hospital executives should aim to develop plans to make quick decisions and to definitively communicate those decisions across hospital workforces and patient populations.

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