CHA | California Hospital Association

FAQs

July 3, 2021

Drawing Upon the Lessons of COVID-19, California Must Modernize its Disaster Preparedness Standards for Hospitals

Proposal will refocus 2030 hospital seismic requirements on emergency services and provide additional time for hospitals to comply as they begin the long recovery from the impact of the pandemic.

1. We've just seen what happened to the condo in Surfside, FL? Won't pushing off the 2030 seismic standard risk hospital worker and patient safety?

Absolutely not. Unlike residential buildings such as the condo in Surfside, *California hospital buildings are already among the safest in the world*. More than 96% of all hospital buildings have met the state's rigorous seismic life safety construction standards for 2020, and the remaining handful of buildings are expected to come into compliance by 2025. The 2030 standard is entirely different than the world-class 2020 *stay standing* requirement.

This means that California hospital buildings are *already* able to withstand an earthquake and patients and workers are *already* protected.

2. Hospitals have known about this requirement for decades. Is this really about needing more time or are hospitals simply trying to get out of doing this work?

Hospitals in no way are trying to "get out of doing this work." Rather, on the heels of the pandemic, where we learned that health care workers are the resource in greatest demand, they are trying to meet the needs of their communities following a disaster while accounting for the massive changes that have occurred in the way care is delivered in the past three decades.

This law was conceived in the 1990s based on that era's data and science. The 2030 standard's assumption that all patient care services will be needed after an earthquake is outdated – today, health care is delivered effectively at sites throughout California's communities, including outpatient clinics, physicians' offices, and increasingly through telehealth and home-based care. It's no longer about a single, massive, centralized building. *Instead of using 1990s strategies based on old data and science, the law must be modernized to reflect how health care is delivered in the 21st century.* This requires a continued focus on health care providers being prepared for disasters of all kinds and ensuring access to what communities need most: emergency services.

Hospitals have already spent years and billions of dollars upgrading their buildings to survive an earthquake. Now that hospital buildings are safe, the focus must be on maintaining access to emergency services.

If this were easy, it would already be done. Instead, nearly two-thirds (64%) of hospitals (274 out of 426) have not yet been able to meet the 2030 deadline. These represent 649 buildings statewide that must be upgraded or else will no longer be available for patient care.

Hospitals want to be able to comply, but if the standard is not achievable, hospitals' ability to keep their doors open is in jeopardy.

3. Aren't hospitals' already recovered from the impact of the pandemic? Why can't you do this construction by 2030, more than eight years away?

Hospitals are continuing to suffer losses from the pandemic, and it will take years to get back to "normal." Even excluding the impact of the pandemic, this mandate – estimated by RAND to potentially cost upward of $100 billion statewide and double that when adding financing costs – would have been practically unattainable. Given the time it will take to recover, it is now fantastical, especially at a time when everyone is working to keep health care costs down.

With hospital margins and revenue forecasts battered by the pandemic, it will be difficult if not impossible to secure financing for projects of this magnitude. Even with federal financial relief, hospitals in the Golden State still endured a net loss of more than $8 billion last year. And the financial losses continue to mount, with California hospitals projected to lose up to an additional $2.2 billion in 2021 and no additional federal relief in sight.

Unless current law is changed, hospitals unable to secure the funding to complete that construction in the next several years will be forced to close their doors. It's important to remember that for projects of this size, planning and design, regulatory approvals, financing approval, and more all begin years before a single shovel touches the earth, and that the entire project timeline is a decade long.

No community should lose its local hospital because of an outdated state law.

4. What's wrong with just giving hospitals more time to meet the 2030 seismic standard?

Both are important, but hospitals need more than just time to make sure they can recover from the pandemic, meet the needs of their communities post-disaster, and most importantly – avoid closure due to a sheer inability to afford the current mandate. The RAND Corporation estimates that unless state law is changed, we are potentially looking at a $100+ billion price tag, without even factoring the added costs of financing.

Hospitals will never, ever waver from their responsibility to their workers, their patients, and their communities, but the truth is that this magnitude of the expense for this mandate – and the risk that carries for hospital closure – is not balanced by any notable benefits. That's why the proposal still calls for tens of billions in upgrades while recognizing that hospitals train constantly for disasters, including internal and external patient transfers, all with an intense focus on strategies to keep patients safe. This proposal takes into account the existing planning and capabilities of *every hospital in California* to manage disaster response, and focuses resources on the needs of this community once a disaster strikes, *in the emergency room, and on the services needed to support emergency care.*

5. Hospitals are claiming they can't afford this. Can't the state just grant exceptions and provide funding for those that can prove hardship?

Opponents to these changes have incorrectly stated that there are hardship exemptions and funds to complete these requirements. That is simply not true. The 2030 seismic standard is state law, and there are no exemptions

and there is no state funding. Unless the Legislature acts to provide relief, there absolutely will be hospitals unable to comply and patients who lose access to care – both during an emergency and at *all other times* – as a result.

6. Hospitals are an essential service that people rely on during and after a crisis. How can you justify fewer services being available in a community experiencing an earthquake?

The focus during a disaster should be on providing emergency services. Routine care can and should be provided outside of the disaster zone.

It is clear that not all services are going to be needed immediately following an earthquake. For example, all of the following and more will be suspended during and after a crisis: knee replacements, plastic surgeries, and colonoscopies. The operational standard at issue with the 2030 deadline should be modernized to apply only to those buildings in which *post-event emergency medical services* are located.

These services include the emergency department, and the resources and services necessary to support it, including food, water, pharmaceutical supplies, clinical laboratory service, radiology service, operating rooms, pre- and post-surgery spaces, and more.

Given that a disaster can result in a surge of patients, every hospital will be required to have capacity above historic levels in buildings that will be able to continue operating.

By definition, this proposal requires that the most critical aspect of health care — *emergency care* — is available to those who need it during and after the next disaster. By creating a network of hospitals with post-event emergency medical services throughout the state, California will be well-positioned to respond to a seismic event, or any other disaster that comes our way.

7. Why are maternity and pharmacy services not on the list of services to be in buildings that would be fully operational? What will happen to people who need those services?

Patients requiring routine maternity care and pharmacy services can safely receive care outside of the disaster zone at nearby hospitals. However, if these patients require immediate care, the emergency department will be available to care for them.

Pharmaceutical supplies in hospitals' emergency caches, which are required by the Centers for Medicare & Medicaid Services in case of a disaster, will be housed in fully operational buildings, and will be readily accessible. Those caches will be replenished following the immediate disaster response.

8. Don't workers need to be assured their jobs will remain after an earthquake?

As we've learned from the pandemic, the greatest resource during an emergency is our state's health care workers.

Those who can safely travel to work after an earthquake, which will undoubtedly damage infrastructure such as freeways, gas and power lines, and communications networks, will be needed to provide emergency care, not non-emergent hospital services. Depending on the situation, those workers may need to temporarily provide that care in a different building on the hospital campus, a different location of a health system, and even in a different city or county outside of the disaster zone.

Health care workers who cannot or need not be on site, should not be put at risk, and be able to shelter in place at home with their families.

Like with other infrastructure in a community, any buildings that need repair can be repaired. Hospitals have demonstrated the ability during the pandemic to build temporary structures where care can be delivered if needed on a temporary basis while any repairs to permanent buildings are made.

Hospitals will always stand with their communities and build back if needed. But they cannot do that if this costly state mandate first closes their doors.

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