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IS THE HEALTHCARE INDUSTRY PREPARED FOR TERRORISM?

All-Hazards “HVA” for Non-Federal Healthcare CBRNE Readiness: A Level Playing Field?

“History will judge harshly those who saw this coming danger but failed to act... In the new world we have entered, the path to peace and security is the path of action.” President George W. Bush, September 2002

Post 9/11, we are in an environment that demands vigilance and action on the part of all sectors of the nation. The principal authorities that guide the national strategy for Homeland Security are found in a plethora of statutes, executive orders, and presidential directives (HSPDs) spanning decades. The 2005 National Response Plan (NRP) evolves from these derivative sources. There was a significant change in expectations for the non-federal sector as the Federal Response Plan (FRP) evolved into the NRP. Hospitals, clinics, and medical personnel have been designated by HSPDs as critical infrastructure/key resources (CI/KR) and first responders/first receivers.

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These realities force the healthcare industry to take a hard look at the readiness of all private and public healthcare facilities. There is a demonstrable and measurable lack of CBRNE readiness in both the urban and rural healthcare environments. The healthcare industry in general and the hospital industry in particular have been the target of mounting “think tank” and public media criticism for their lack of all-hazards preparedness, particularly against bioterrorism threats. Findings of the legislative branch’s “watch dog,” the Government Accountability Office (GAO), have supported these public observations.

The industry’s professional leadership community has shown little appetite to advocate for aggressive voluntary compliance. Recent economic challenges in the industry and the voluntary nature for meeting the NRP’s expectations have led to a mixed response. The argument that CBRNE readiness is a totally “unfunded mandate” is weakened by the availability of significant funds for this effort through federal grants administered by a number of federal agencies. GAO reports have identified serious problems associated with the administration and oversight of the funding and distribution process at federal, state, and local government levels. Little of the 4-plus billion dollars in first responder grants have reached the hospital level; indeed, of the \$4,602,136,000 worth of federal first responder grants awarded in fiscal years 2002-2004, only \$1,706,176,534 (or 37%) had been drawn by April 2005. If significant amounts of these funds could be channeled directly to the healthcare community, with clear direction and appropriate oversight, CBRNE readiness could become a largely self-funded exercise.

Soon after the 9/11 attacks, analysts at the American Hospital Association (AHA) concluded that it would cost the nation’s 4,900 hospitals upwards of \$11 billion to improve their ability to respond to a CBRNE-type attack. The exact amount of funding that has reached the hospital level is difficult to calculate, but we do know that appropriated funds were received from the Department of Health and Human Services (DHHS), the Department of Homeland Security (DHS), the Department of Justice (DOJ), etc. Also, according to the GAO and DHHS, the Office of Inspector General (OIG) reports that substantial funds intended for hospital use were diverted to other mission-critical areas and that some funds were not used for their appropriated intent. Unlike the federal sector, many healthcare organizations (both private and public, for-profit and not-for-profit) are expected to comply on a voluntary basis. There are refreshing examples of voluntary compliance within the industry; however, there has been little success across the nation. Small and rural facilities are the least prepared.

Extant (traditional) healthcare accrediting mechanisms focus on broad institutional issues: direct patient-centered care, staffing, medical staff issues, patient safety (narrowly defined by national patient safety goals), facilities engineering, human resources, and environment of care, primarily based on historic hazards. The movement toward a more patient-focused approach in the survey process is commendable and appropriate.

A recent GAO report (04-850) seriously questioned the effectiveness of the nation’s leading hospital accrediting organization. The report was highly critical of the current oversight of the organization and suggested that Congress review the special power entrusted to the organization’s hospital oversight mission. DHHS and its agent, the Center for Medicare and Medicaid Services,

received their share of criticism and were asked to provide closer supervision over the accreditation function. This particular organization has been given the unique power by Congress to determine the trustworthiness of hospitals to provide care in accordance with a set of standards codified in federal law as “conditions of participation” (COP). This designation “deemed status” allows the hospital to seek and receive federal reimbursement for patients treated under Medicare and Medicaid programs. Additionally, the accreditation status or its equivalent designation from other authorities are of significant importance to hospitals in their business dealings with the insurance and capital lending markets.

Various government agencies (the Occupational Safety and Health Administration (OSHA), the Environmental Protection Agency (EPA), the Department of Transportation (DOT), the Food and Drug Administration (FDA), etc.) informally rely on this process as their first line of defense as a proxy or “trip wire” for certain areas of compliance. Post 9/11, oversight for healthcare CBRNE readiness by all extant accrediting bodies has been weak in all healthcare provider groups along the continuum from hospitals to assisted living facilities. GAO and OIG reports repeatedly identify a serious lack of strong advocacy in CBRNE readiness within the non-federal healthcare provider community.

The healthcare provider community is not alone in its lackluster advocacy for a timely and strong CBRNE readiness effort. The nation’s leading healthcare professional organizations show little public policy interest in homeland security readiness. A comprehensive review of the last 2 years of official publications, conference presentations, and continuing professional education offerings shows a void of open support for homeland security readiness.

The industry’s oversight structure and

standards are subject to elements of gaming and manipulation. The system requires healthcare entities to develop sophisticated all-hazards vulnerability analyses (HVA) to set financial and action priorities. CBRNE readiness efforts, even in areas subjected to past terrorist events, rarely compete successfully for priority funding. As a result the system often allows organizations to use subjective analysis, which fails to consider serious potential threats. Recent changes in the private healthcare accrediting industry toward a more focused process has done little to change the systemic weakness relative to CBRNE readiness. A phone survey of selected hospitals in the first quarter of 2004 revealed that less than half of these organizations were subjected to an in-depth evaluation of their emergency management process.

The extant assessment systems for healthcare facilities do a reasonably acceptable job of evaluating patient-centered care. There are many critics who would not agree with that statement; however, the new patient focus is a definite improvement over the past. The broad institutional healthcare focus of these mechanisms and those who perform them leaves in-depth evaluation of CBRNE readiness poorly served. Other governmental oversight efforts (at all levels) are narrow and deep and do not apply broadband institutional knowledge base necessary to assess all aspects of healthcare readiness. Many of these organizations (OSHA, EPA, FDA, the U.S. Department of Agriculture, etc.) are outpacing traditional mechanisms as they move responsibly forward to meet the readiness threat challenge.

Healthcare CBRNE readiness must be allowed to take its rightful place as a priority enterprise without compromise. Institutional apathy must be dealt with quickly and forcefully. Professional associations, healthcare facility boards, and executive leaders who fail to “buy in” because these expenditures are perceived

as a “bad return on investment” face the condemnation of those for whom they are morally and ethically obliged to protect: patients, staff, visitors, vendors, and a trusting community.

Our research found that the federal healthcare system has been far more responsive to CBRNE readiness. We attribute this to more competent financial administration and the care and enthusiasm that comes with federal mandates embedded in performance requirements.

The following entities are at risk:

Governing Bodies. The emergence of the climate of reform at the corporate governance level has and will have a significant impact on the healthcare industry. For-profit operations with stockholders are vulnerable to the provisions of the Sarbanes/Oxley Act (SOX). Many states and other governmental bodies have adopted SOX-like provisions. Prudent hospital board members have taken special care to evaluate the legal exposure of their directors and officers in this new unpredictable environment.

Patients. Recent studies have identified healthcare environments as dangerous places. The highly publicized Institute of Medicine’s (IOM’s) “To Err is Human” revealed alarming numbers of infections acquired in these settings. Infection control is difficult under the best of circumstances; add to that the threat of bioterrorism agents or newly emerging diseases and you are dealing with a problem of catastrophic proportions. Other terrorist threats, including CBRNE agents, present enormous challenges to the organization. The protection of patients in these potentially hostile environments can only be achieved through the application of readiness principles: mitigation, preparedness, response, and recovery.

Employees. Central to any successful healthcare readiness program is a well trained, well equipped, and well led staff. Employees must be secure in the knowledge that their training, equipment, and

leadership are equal to the challenge. A lack of confidence in any of these areas places the entire readiness enterprise at risk. The OSHA community has been active in updating its rules and regulations to meet the terrorist threat environment; even so, recent GAO reports indicate that the lack of available personal protective equipment for hospital employees places the entire readiness effort at risk. Inattention to realistic emergency disaster training exercises has also been identified as a pervasive weakness in the healthcare community. Hospital employees have been designated as first responders/receivers and must be ready to do their duty.

Trusting Public and Community. Perhaps the greatest disparity in the perception of healthcare readiness may be found in the difference between the reality and actual level of readiness and a trusting public’s expectations. The level of public trust in medical and hospital institutions has remained relatively high, even with the recent media attacks on the lack of bioterrorism readiness in the industry. Hospitals enjoy an 80% level of public trust. (That is, “if I need care the hospital has taken the necessary steps to protect me from harm.”) Prominently displayed signs on accreditation, certification, and licensure greet patients in most healthcare facilities, and local media ads extol patient safety and quality of care. These activities are designed to reinforce a public sense of protection. Risks associated with these public assurances center on the reaction of a disillusioned public when and if the institution fails to meet expectations. Recent cases of not-for-profit hospitals losing their tax protection over perceived failures to meet their moral and legal obligations to the poor in their communities is frank evidence of the consequences of not meeting public commitments.

Common Misconceptions and Myths About CBRNE Readiness

Common misconceptions and

“urban/suburban/exurban/rural” myths about the need for CBRNE readiness abound. These include the following.

Myth: Federal terrorism response plans call for immediate assistance to sites of significant terrorist attacks. The NRP, through the National Incident Management System (NIMS), provides for limited assistance for the first 72 hours following a significant terrorist event. The timeliness of federal level assistance is a function of the nature of the incident, national security estimates, and federal mission priorities. Multiple national incidents may delay federal assistance for unknown time frames. An organization’s survival depends on its own vigilance and application of the readiness elements of mitigation, preparation, response, and recovery.

Myth: According to our HVA experts, the probability of our area being a terrorist target is nil because we are a small rural facility. Agro-terrorism is a real threat, and the first lines of defense are small rural or critical care facilities. The importance of their ability to detect and treat cannot be overstated. Rural areas have the highest probability of being the target of “crop duster” attacks, as crop dusting is a familiar activity in those areas.

Myth: We are a suburban facility. The large metropolitan facilities and local government planners are preparing for terrorist response, and the probability of our direct involvement is low. Clustered urban healthcare facilities are seen as soft infrastructure targets with a high probability of being attacked with a dirty bomb. Destruction of these healthcare assets would force care to the suburbs and beyond. This strategy, whether the medical centers are the primary target or are attacked in tandem with a high profile urban target in the vicinity, is designed to maximize lethality and deny treatment for victims.

Myth: We have not formally participated in local or regional planning or received any federal grant funds for

CBRNE readiness, so we are not obligated to have an emergency management plan that is compatible with NIMS. HSPDs have designated all hospitals as CI/KR and medical staff as first responders/first receivers. The DHHS’s Center for Medicare and Medicaid Services requires all-hazards preparedness (including CBRNE) as a COP.

Myth: Everyone knows that terrorists are looking for spectacular, high victim count, high profile targets. We don’t meet any of those criteria so we have little to fear. Recent intelligence estimates indicate that the likelihood terrorists would choose one large target has reduced by 25% and that the selection of multiple smaller targets has increased. Target selection is partially a function of access; as larger targets “harden,” the selection of “softer,” more vulnerable targets becomes more likely. Recent insurance industry target modeling also reflects a shift away from larger targets.

Myth: Hospitals are unlikely terrorist targets and if they were selected they would be large famous medical centers in urban settings. It is improbable that a small town healthcare facility would be targeted. Recent highly suspicious activities involving fake federal and accrediting hospital inspectors appearing in the middle of the night asking for building tours have little common pattern relative to size, geography, ownership, or specialty. A spate of unexplained intense interest in specific areas of healthcare facilities, focused on pharmacy and radiology departments, had little in common with facility characteristics. Theft and questionable purchases of used ambulances appear to be geographically random events. The use of vehicles as future terrorist delivery systems is commonly accepted, with VIP limos, ambulances, and mortuary transport vehicles heading the list. One unsettling aspect associated with the fake inspectors centers on the commonly accepted hierarchy of threat recognition indicators (TRI). Many experts classify these indi-

cators along a seven-stage continuum starting from “marking the target” to “attack.” Stage three is characterized as “gathering information” and stage six as “rehearsal.” The troubling question is, are these fake hospital inspection activities stage three (if so, it is early in a normally patient and protracted process) or are they stage six (if so, the next stage is “attack”). The acquisition and short-term storage of ambulances would appear to be a late stage activity.

Myth: Hospital personnel, particularly professional staff, are all trained in recognition and treatment of CBRNE-related casualties. Our doctors and nurses are already trained to treat mass casualties of all types. In reality, most hospital personnel are too busy to participate in CBRNE education and training exercises, so when the time comes there is no guarantee that they will know what to do. Post 9/11 CBRNE emergency management exercises and their after-action/lessons learned reveal that the lack of a CBRNE working knowledge base among health professionals (including recognition and treatment of CBRNE casualties) was and is a significant weakness in the system. The need for health professionals’ involvement in all-hazards planning and their active participation in realistic CBRNE exercises is essential to meet future threats.

Myth: Hospital personnel at all levels are willing to actively participate in a real CBRNE hostile environment, even if it means placing themselves in harms way in the event of an actual CBRNE threat environment. Recent experience with the SARS threat brings into question the validity of this general statement. Incidents of refusal to work in such an environment were not unusual in this event. One state survey revealed that half of physicians and nurses answered “no” to a question about their willingness to participate in a real CBRNE event in a non-hospital setting. This is significant in that during a high

percentage of real CBRNE events the hospital will be on lock-down. There is no substitute for strong leadership, effective training, and understanding in the use of protective equipment and confidence in personal survival in a CBRNE environment.

Myth: The healthcare system has been tested by the Oklahoma City bombing and the 9/11 attacks on New York and the Pentagon. We have sustained terrorist attacks and we understand a lot more about how to deal with them. We gained insight from those experiences; however, they were largely mortuary management events. One significant lesson learned was that healthcare facilities were ill prepared to deal with huge crowds looking for friends and family members. An accompanying biological or chemical attack would have resulted in the immediate contamination of area healthcare resources.

Myth: CBRNE responses are not that different from ones used to deal with natural hazards and the occasional HAZMAT event. We have been able to deal with multiple catastrophic events; most recently, four major, destructive hurricanes in one season. Managing CBRNE risks requires the understanding of significant differences between natural and manmade terrorist events. To identify a few: predictability, casualty production, ratio between property loss and loss of life, post event recovery time, economic impact, public acceptance of protracted loss of personal freedom, and the “terror factor” psychological impact. Natural hazards are, for the most part, predictable and bounded by geography. (For instance, hurricanes. Citizens in Nebraska feel little anxiety over a Florida hurricane.) Terrorist attacks anywhere in the nation create a psychological trauma response in most inhabitants.

Myth: Our long experience with natural hazards has allowed us to incrementally improve on mitigation, preparation, response, and recovery, giving us a degree of comfort in our

ability to deal with future events. We have, through trial and error, been able to deal with all hazards. However, expected new strategies from the terrorist community will test our creativity and resolve. We must look and prepare for new terrorist tactics: planning CBRNE attacks to coincide with predictable natural hazard events, such as hurricanes as they make landfall, peak flood levels, or immediately following earthquakes or coinciding with aftershocks; the introduction of different biological agents at peak known endemic or pandemic events; the introduction of chemical agents to co-mingle with smoke from forest fires; etc.

Myth: Making the decision to “protect in place or evacuate” in a CBRNE terrorist event is about the same as preparing for a category-three hurricane, which we do almost every year. In the case of a hurricane you have the advantage of knowing hour by hour the location, velocity, and direction of the hazard. There are essentially two elements to deal with in this situation, wind and water. When dealing with an unanticipated chemical agent attack the decision window time is short, and agent identification and knowledge of its characteristics and understanding wind speed and direction, concentration of agent, structural integrity of the building, which exit routes are clear, etc., is necessary for action if the decision is made to “protect in place.” Depending on the agent there are multiple variables to consider; for example, do you go to the top floor or to the basement? Who receives the limited amount of protective equipment? A decision to evacuate is no less complex. You get the picture.

Conclusion

The nation’s 21st century is filled with the possibilities of unimaginable advances in our ability to make our citizens healthier and longer-lived. Shadowing that optimistic environment are dark and sinister forces dedicated to

the destruction of that vision. Protection of the nation’s healthcare infrastructure and the future health and safety of all healthcare industry stakeholders is a daunting task. The NRP, through the implementation of the NIMS, provides the industry with an integrated framework and process to effectively meet future terrorist threats. The greater healthcare industry must adopt a proactive posture of meeting NRP expectations. An important step in the process is for the industry to adopt an “intellectually honest” attitude in the HVA process. Hospitals, in particular, find themselves in the unique position of having the timely and critical mission of treating victims of terrorist attacks and the additional duty of protecting patients, employees, visitors, and vendors. Expert congressional testimony indicates that the threat is real and that it is a matter of “not if, but when.” Mounting evidence points to a special interest by terrorists in using healthcare facilities as future targets. This interest is wide-ranging, selecting potential targets without regard to geographic location, size, ownership, or specialty care.

Over the past 50 years the hospital industry has adjusted to progressively more demanding all-hazards requirements. Recent history shows us that the system has effectively dealt with non-terrorist all-hazards events. The vast majority of the nation’s hospitals possess documented evidence through government or private accrediting mechanisms that they are prepared to deal with the HSPD’s definition of all-hazards events. Still, observers from all quarters question the healthcare industry’s preparedness to meet the challenge posed by terrorism.

The hospital industry is not alone in the private and public sector in the apparent lack of zeal to voluntarily comply with NRP readiness expectations. Recent congressional and media speculation that the DHS will need to move to federal mandates for compliance has not missed the attention of leadership in

these sectors. Delaying action until there is “proof” of its necessity—a significant hospital terrorist attack—would be a cost the industry can ill afford.

Author’s Recommendations: *This material should not be used as legal advice. Differences in state, tribal, territorial, and multi-jurisdictional laws prohibit the use of generalized legal application. The author recommends the recently published (Dec. 04) American Health Lawyers Association paper “The Emergency Preparedness, Response, and Recovery Checklist: Beyond the Emergency Management Plan,” pp. 1-38, a review of NAFTA 1600 and OSHA recommendations.*

About the Author

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Georgia. Dr. Blair is a career retired Army Colonel with 28 years of active service. His notable assignments include service as Chief of Staff of the 7th Medical Command in Heidelberg, Germany, and as Chief Executive Officer in medical facilities ranging from combat field and evacuation hospitals to medical centers and healthcare systems. He also served as USAREUR Deputy Chief Surgeon for Medical Support Services, Safety and Security Readiness, at the height of the “Baader-Meinhof” and “Red Brigade Euro-Terrorism” period. Serving as Consultant to the Army Surgeon General for Healthcare Administration, USAREUR, Dr. Blair successfully guided the JCAH re-accreditation of 7th MEDCOM Medical Treatment Facilities. His notable Pentagon assignments include: Chief of Education and Training, Office of the Army Surgeon General, which at that time was the largest healthcare educational system in the free world, and Surgeon General’s principle representative for the Comptroller of the U.S. Army’s study of the reorganization of the Army Medical Department’s CONUS healthcare delivery system.

Dr. Blair’s notable assignments in the private sector include: Vice President for the Hospital Corporation of America, MIDEAST Limited; Project Manager for the Saudi Arabia National

Guard Medical Services Project in Riyadh, Saudi Arabia; and Senior Consultant to the Pacific Healthcare Management Corporation. Dr. Blair also completed a prestigious public sector assignment as Deputy for Operations for the South Carolina Health and Human Services Finance Commission, South Carolina’s Medicaid Agency, budgeted at \$2.2 billion in 1995. In 1996 Dr. Blair established J. Blair & Associates. With this organization he served as an Independent Contractor with the Joint Commission International collaborating on Middle East projects and worked with Native American Tribes that had opted out of the Indian Health Service under the Indian Sovereignty Act. Dr. Blair’s academic appointments include Adjunct Professorships at: Baylor, Tulane, the University of South Carolina, and the Medical University of South Carolina. He also served as Research Professor at the University of South Carolina School of Public Health. Among his awards and decorations are two Bronze Star Medals and a Purple Heart.

Learning Objectives for “Is the Healthcare Industry Prepared for Terrorism?”

After reading this article, the participant should understand the following:

- 1.) The complexities associated with the integration of the private and public healthcare sector into a comprehensive NRP.
- 2.) Commonly held misconceptions which lead to the non-federal healthcare industry’s apathetic attitude toward CBRNE readiness and the reality of the terrorist threat to the industry.

Complete this CE test with a grade of 70% or above to earn one CE credit. Circle the correct answer for each question and send the test, along with a \$15 payment to CHS Headquarters by fax at (417) 881-4702 or mail at 2750 E. Sunshine, Springfield MO 65804. Or, take this quiz and pay online at www.acfei.com (click “Online CE”).

CE Test for “Is the Healthcare Industry Prepared for Terrorism?”

1.) True or false: Homeland Security Presidential Directives have identified hospitals as critical infrastructures and hospital staff as first responders, and expect them to be full partners in the NRP

through NIMS.

- A. True
- B. False

2.) True or false: The healthcare industry’s professional associations have demonstrated their strong support for healthcare homeland security CBRNE readiness by making it a priority public policy issue and have used the power of their professional education systems to influence their membership.

- A. True
- B. False

3.) A phone survey of selected hospitals in the first quarter of 2004 revealed that what percentage of these organizations were subjected to an in-depth evaluation of their emergency management process?

- A. More than 80%
- B. 70%
- C. 60%
- D. Less than 50%

4.) True or false: Recent intelligence estimates indicate that the likelihood terrorists would choose one large target has increased by 25% and that the selection of multiple smaller targets has decreased.

- A. True
- B. False