CHCER
Center for HealthCare Emergency Readiness
*To Treat and Heal Them, You Must Keep Them Safe*

# US Healthcare Sector and Homeland Security Readiness


**A White Paper Prepared by:**

**Center for Healthcare Emergency Readiness (CHCER)**
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# Introduction

**OBSERVATIONS ON THE POST 9/11 PUBLIC HEALTH AND HEALTHCARE SECTOR'S EFFORTS TO MEET ITS EXPECTED ROLE AND RESPONSIBILITIES IN THE NATION'S HOMELAND SECURITY STRATEGY TO PREPARE FOR AND RESPOND TO KNOWN AND UNKNOWN THREATS (ALL-HAZARDS)**

**Author's experience**

The author has a fifty-plus year career in progressive levels of responsibility within the Private, Public and Military Healthcare Sectors. Chief Executive Officer at military hospitals ranging from Combat Field, Combat Evacuation, Community, Medical Centers, and Major Healthcare System. Chief of Staff, 7th Medical Command and USAREUR Deputy Chief Surgeon - Medical Support Services (Safety and Security Readiness), Senior Healthcare Consultant for US Army Surgeon General, Chief, Education and Training, Office of Army Surgeon General. Vice-President HCA Middle East, Ltd. Health and Human Services Finance Commission Deputy Director, Operations, State of South Carolina, Independent Contractor, JCI. Fifteen years of preparing healthcare organizations to meet their expected role in the nation's strategy for first, CBRNE and later all-hazards preparedness for Homeland Security protection. Author of two books on Hospital and Healthcare all-hazards protection and numerous articles on several expert domains dealing with hospital administration

**Specialties:**
•Safety and Security
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**Certifications**
•Fellow, American College of Healthcare Executives, Initial 1988, Re-certification 2010
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**Center for HealthCare Emergency Readiness (CHCER)**
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The Center for Health Care Emergency Readiness (CHCER) was created to assist hospitals in meeting their expected role as full partners, in the nation's strategy for Homeland Security Healthcare Emergency Preparedness. Building on existing efforts to meet this demand CHCER strengthens existing capabilities. The organization does not certify nor accredit its client facilities. Extant external evaluation mechanisms designed to Accredit or Deem organizations for federal payment of its beneficiaries are necessary but not sufficient to meet the demands of today's all-hazards hostile environment. We have designed our program to be less threatening which promotes sharing of information, indeed, this adds value to the process and promotes better outcomes. CHCER assessments focus on preparing for and responding to known and potential threats.

**Founding of the Center for HealthCare Emergency Readiness CHCER)**

Following the 9/11 terrorist's attacks on New York City and the Pentagon a small group of like-minded senior domain experts in a number of health related fields bonded by a desire to contribute in some meaningful way to an effort to help make the nation more secure from future threats be they Natural or Man-Made. Our first step was to undertake a self-funded nine month study of the nation's' Public Health and Non-Federal Healthcare sector for their understanding of their expected roles in Homeland Security. We were quite convinced that the industry had little understanding and even less interest in becoming a full partner in such an endeavor. This sent us back to the research documents. We visited our professional organizations for guidance and were shocked that they did not see any type of advocacy role and that someone else would have to pick up the gauntlet. We developed our program which was no longer a gap analysis but was a comprehensive, holistic process with some 500 interrelated elements to assess all-hazards readiness. It has a lot of moving parts; no cookie-cutter model. Understanding that readiness is not a destination, it is a journey.

**DISCLAIMER**

This White Paper offers no private or professional advice. The reader is encouraged to use good judgment when applying the information herein contained, and to seek advice from appropriate qualified domain professionals. The author shall in no event be held liable for any loss or other damages, including but not limited to special, incidental, consequential, or other damages. The reader is responsible for any subjective decisions made as to the content and or its' use.

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# The Non-Federal Healthcare Sector and Homeland Security Readiness

***"The history of man is a graveyard of great cultures that came to catastrophic ends because of their incapacity for planning rational, voluntary reaction to challenges"***
***-Eric Fromm***

The non-federal healthcare sector, with its Public/Private blend, faces the usual set of regulatory requirements. Effective oversight of the healthcare industry has always been challenging in a free, pluralistic healthcare industry, governance is a fragmented and complex undertaking. In addition to the challenges of preparing for increasingly frequent and robust natural disasters and evolving infectious diseases, the Emergency Management function is now struggling to respond to unprecedented levels of workplace violence from both internal and external sources.

State and Tribal sovereignty and the dichotomy between federal mandatory and non-federal voluntary compliance embedded in the National Response Framework (NRF) and National Strategy for Homeland Security adds to an already enormous undertaking. The realization of an effective seamless bulwark against all-hazards threats depends on a full partnership between and among all national economic sectors.

The federal healthcare sector has been mandated by Congress, Presidential Executive Directives and Homeland Security Directives to move toward National All-Hazards Readiness goals. The Oklahoma City Murrah Building bombing, 9/11 Terrorist Attacks and more recently the Katrina Gulf Coast Disaster have forced the move from a Cold War, WMD-focused strategy to one of All Hazards Readiness. However, the federal healthcare sector only accounts for approximately 10% of the nation's delivery capabilities.

The non-federal healthcare sector owns approximately ninety (90%) percent of the nation's healthcare delivery capacity, and its' professional leadership community has shown little appetite to advocate for aggressive voluntary compliance within the National Response Framework (NRF).

Recent economic challenges and the voluntary nature for meeting the nation's strategic expectations have led to a mixed industry response.

The lack of all-hazards preparedness within the healthcare industry in general, and the hospital sector, in particular, has been the target of mounting "think tank" and public media criticism. Findings of the legislative branch's "watch dog" the Government Accountability Office (GAO) have supported these public observations, leaving many to characterize the non-federal healthcare sector as the "Weakest Link in the Homeland Security Chain".

The initial federal effort toward designing and constructing new healthcare facilities and retrofitting existing structures to reduce the harmful effects of known hazards, reinforced by evolving "best practices and lessons learned" have contributed to a significant improvement in the workplace protection for current and future federal healthcare workers and other stakeholders.

The non-federal healthcare sector has not followed the federal sector's lead to mitigate vulnerabilities associated with known hazards through design and construction of their facilities, and for the most part, have not taken advantage of lessons learned and best practices so skillfully used by the federal sector.

Influential segments of the healthcare industry have done little to advocate for or facilitate a realistic movement toward a non-federal healthcare partnership in the National Response Framework. This attitude of apathy and denial for a meaningful partnership in the Nation's strategy for healthcare Homeland Security readiness/protection is clearly seen in major segments of the Sector. The 2006 AIA Healthcare Design and Construction Guidelines for Healthcare Facilities, known as the "BIBLE" for Design and Construction of healthcare facilities is a timely example. The publication reflects a passive "business as usual" guidance and remains silent on the fundamental changes necessary to protect all healthcare stakeholders exposed to an increasingly hostile environment in general, and terrorist activities in particular.

The opportunity lost by the non-federal healthcare industry to introduce known strategies which would mitigate vulnerabilities to all-hazards threats, maximize physical security protection through design and construction of new facilities cannot be overstated. The 21st century healthcare industry is in a building boom rivaled only by the Hill-Burton construction era following World War II.

Dual benefits associated with designing and built-in features that protect against bioterrorism have the secondary beneficial effect of dealing with current infection control challenges. Designing and building in features, which facilitate effective isolation, triage, decontamination, or airtight envelopes, support decision-makers choices in "protect in place or evacuation" –life and death decisions. The recent trend in the design and construction of "green" facilities with its energy saving and patient-centered therapeutic effects have some serious unintended consequences for important aspects of safety and security for healthcare locations.

Hospital Boards and C-suite executives have failed to staff and fund their "Public safety and security functions" and lost opportunities to design and construct facilities which reduce the burden of an inadequate facility security force has been recognized for some time. Increased violence in hospitals, and particularly Emergency Departments, has become an unfortunate national trend, while shifting demographic compositions and encroaching gang-related violence have challenged the safety and security of previously secure neighborhoods. Women employees in healthcare organizations are among the nation's most victimized groups in the country. Combining the growing workplace violence with other hazards faced by healthcare workers produces an increasingly hostile employment environment.

Important recommendations from the 9/11 Commission Report and the follow-on HR 1 and P.L. 110-53, Title IX "Implementing Recommendations of the 9/11 Commission Act of 2007" have not been realized.

*Command, Control, and Communications*

**Recommendation**: Emergency response agencies nationwide should adopt the Incident Command System (ICS). When multiple agencies or multiple jurisdictions are involved, they should adopt a unified command. Both are proven frameworks for emergency response. We strongly support the decision that federal homeland security funding will be contingent, as of October 1, 2004, upon the adoption and regular use of ICS and unified command procedures. In the future, the Department of Homeland Security should consider making funding contingent in aggressive and realist training in accordance with ICS and unified command procedures.

**Recommendation**: We endorse the American National Standards Institute's (ANSI) for private preparedness. We were encouraged by Secretary Tom Ridge's praise of the standard, and urge the Department of Homeland Security to promote its adoption. *We also encourage the insurance and credit-rating industries to look closely at a company's compliance with the ANSI standards in assessing its insurability and creditworthiness. We believe that compliance with the standard should define the standard of care owed by a company to its employees and the public for legal purposes. Private-sector preparedness is not a luxury: it is the cost of doing business in the post 9/11 world. It is ignored at a tremendous potential cost in lives, money, and national security.*

We find little evidence that the nation's insurance, credit-rating or capital lending industries have adopted procedures suggested by the Commission. There is little evidence that existing oversight mechanisms monitor this aspect of the 9/11 guidance.

Serial attempts to secure sensitive information from hospitals over the post 9/11 years indicate that there are real threats to the nation's hospitals. The FBI, in November, 2001, alerted hospitals in Houston, San Francisco, Chicago, and Washington that they had been identified as near-term targets for new homeland terrorist attacks. Repeated incidents of late night visits to hospitals across the country by imposters using fraudulent official state, federal, and private accrediting credentials poses serious concern to the industry. Additional incidents of unusual interest in hospital nuclear medicine operations and pharmaceutical stockpiles by unidentified persons are unsettling.

Other less intrusive activities such as purchases of used ambulances by individuals without apparent connections to the healthcare industry, random theft of laboratory and physician white coats, and identification tags add to this concern. These incidents do not have any common element with regard to geography, size, ownership, or specialty. Recent discoveries of "cloned" emergency vehicles indicate that there is less risk in creating "look alike" vehicles than theft or purchase of these potential bomb delivery assets. The lack of other common characteristics among the targeted facilities indicated to law enforcement officials and other federal officials that the only common factor is that they are hospitals.

International antiterrorism experts have identified a series of progressive steps used by Terrorists groups to prepare for and execute their attacks. They are Terrorist Recognition Indicators (TRI) classified along a seven-stage continuum from "marking the target" in Stage One, to "attack" in Stage Seven. Stage Three is "gathering information" and stage Six is "rehearsal". The troubling response question is, are these visits by unknown persons "Stage Three" or "Stage Six"? Either case must be taken seriously.

Hospitals and Clustered Urban Medical Centers are seen as soft targets and are desirable as stand-alone targets or in tandem with another high profile target in the area. Many do not have the option to place

distance or barriers between the structures and vehicle borne bombs. The opportunity to kill and injure huge numbers of caregivers and patients and the secondary effect of destruction of healthcare facilities and denial of care for area victims enhances the terror effect and produces a terror multiplier effect (TME).

Urban Area Security Initiative (UASI), State Homeland Security and Buffer Zone Protection Grants have increased protection for 'City Centers", however, state and area level fund managers have difficulty identifying healthcare sector recipients of these funds. Destruction or severe disruption of any clustered urban health center pushes emergency treatment to suburban, exurban and rural healthcare facilities, which are far less prepared to deal with mass casualties.

Intelligence reports and insurance modeling activities indicate that the likelihood of terrorist selecting one large target has reduced by 25%, Target selection is partially a function of access, as surrounding facilities are hardened, the more likely the unprotected will be targeted.

Responses from recent American College of Healthcare Executives (ACHE) surveys sent to healthcare Chief Executive Officers located in hospitals across the nation indicated that all-hazards readiness was not among the top ten major concerns in hospital C-suites. These respondents were not "rank and file" members of the profession they are sector leaders in whom all stakeholders place their faith and confidence.

Foremost among these stakeholders and the most vulnerable are the Patients who place their health/survival on their decisions, Staff/Employees depend on their leadership to provide and maintain a safe workplace, Boards, depend on them to make sound decision and provide advice on which their reputations and fortunes depend, Investors depend on their stewardship for sound fiscal operations. Areas in which they are the largest employer Businesses depend on them for business continuity and economic viability. Communities depend on them to be prepared to support them in times of crisis. Insurers, Capital Lending Organizations, Taxpayers, at all levels of government, are at risk when the healthcare organizations' Leadership fails in its duty to protect their structures and most importantly their vulnerable charges, Inpatient Populations.

A companion survey asked for an update on current building and construction of new or expanded facilities, none of the respondents surfaced activities related to the mitigation of All Hazards vulnerabilities.

The flow of All Hazards threat information shared with the public has diminished over the last number of years. Press accounts indicate that there has been a programmed shift away from open source terrorist threats to avoid undue stress and possible panic in the population. We question the wisdom of this approach. The greatest disparity between the reality of non-federal healthcare preparedness and the perception of that readiness is found in the trusting public. Eighty percent of the general public indicated that they are confident that their community hospital is prepared to provide necessary care in the case of future disasters. They, however, did not believe that healthcare systems above the Community level was prepared to effectively deal with disasters.

The healthcare professional media and recently the popular press knowingly or unwittingly have contributed to a false sense of security about the industry's readiness to deal with all-hazards threats. The cavalier manner in which "quality and safety" rankings of the nation's hospitals have been published and disseminated has led to a major misrepresentation in the level of facility safety and security. The "safety" in "quality and safety" has morphed into the exclusive domain of clinical practice, rather than the safety and security required to ensure continuity of operations in case of All Hazards Events.

Pronouncements to the general public that a hospital is among the "Top 100 safest places to receive care", "Best of the Best", "Best Place to Work" without including a physical safety variable is problematic from a moral, ethical and perhaps a legal standpoint. Our informal survey of the general public leads us to believe the "man/woman on the street" views hospital safety as "secure from physical harm or loss of personal property".

Recent national reports on Public Health and Healthcare preparedness, Trust in America's Health, etc. are of limited value in measuring preparedness progress realistically, for several reasons: 1) Assessed indicators change each year 2) Heavy reliance on self-reported readiness 3) Interest groups and Marketing departments taking selective information "out of context" from the report and spinning it to promote misleading evidence of progress or quality.

If past is prologue, it teaches us that Americans are reluctant to enthusiastically prepare for known or perceived danger, even in the face of existential threats. This propensity for reactive behavior is legion and is a cultural trait is found in many areas across the Healthcare Delivery Sector. It exists in the culture with few exceptions; while provides readily accept advances in clinical technology and embrace its use, the industry must be pulled "kicking and screaming into the "Wired World of Administration" electronic health records, electronic prescriptions etc. A new and somewhat novel view of Americans' response to disaster events is found in Kevin Rozario's book, *The Culture of Calamity: Disasters and the Making of Modern America*. He posits that over the last four Centuries, disasters have become assimilated into American concepts of progress, modernization, capitalism, and national security. Whatever forces are driving national preparedness behavior it leaves the country at risk and manifests itself in a private sector apathy and denial which has retarded preparedness in one of the most important all-hazards support sectors.

The shift of attention from the threat of Bioterrorism to Avian Flu (Pandemic) as a substitute for the more immediate threat of Bioterrorism appears to have reduced the public's level of anxiety, Bird Flu, a known threat which is real but far away appears to be less threatening, while the specter of a sudden bioterrorism attack, without warning, is terrifying.

The Public Health and Healthcare sector (HPH) is one of the eighteen sector-specific governmental/economic entities identified for special infrastructure protection by the Department of Homeland Security (DHS), in its' post-9/11 role to secure the overall infrastructure and economy from catastrophic attacks. The HPH sector has many characteristics in common with the other seventeen identified in the National Infrastructure Protection Plan (NIPP), and there is common agreement that without important elements of the nation's infrastructure sectors, life as we know it would change dramatically. The HPH sector is unique among all the other economic sectors in that it is directly or indirectly involved in all hazardous events, be they naturally occurring or man-made; i.e., the Healthcare sector responds to thousands of events every day and severe trauma and CBRNE accidents are daily occurrences. As "just in time" supply chain deliveries create challenges for the Transportation Sector, so

the increased density of traffic has its HPH sector impacts on the nature and number of transportation vehicular accidents, frequency of hazardous spills and most importantly, preparing for all-hazards readiness. The increasing undocumented immigrant population creates challenges for many economic sectors and the HPH sector experiences direct and indirect impact, with the cascading effect of the spread of communicable diseases among this population is difficult to assess.
Within the HPH, each time there is loss of radioactive materials (cesium 137), chlorine or a host of other items which could be useful to those who would do us harm, it poses a potential preparedness and response action from the sector.

The growing list of threats to the sector are not confined to the US; increased internationally based terrorist plots characterized by last year's aborted seven-plane London to U.S .terrorist plot. The recent conviction of the Lodi California's terrorist would target "Hospital and Super-Malls". The Al Qaeda-trained bomber testified to a nation-wide plan to bomb hospitals and other "big buildings". To date, the existing large cells of "Hezbollah" groups in the U.S. have been content with their lucrative smuggling activities to raise funds for terrorist activities outside of the United States, however, the recent assassinations of top leaders in the Middle East has prompted the FBI to place its domestic terror squads on 24/7 alert. Prior to 9/11 Hezbollah had killed more Americans than any other known Islamic terrorist group.

There is an evolving consensus that the nation's greatest fear is a domestic nuclear attack in the form of a "crude nuclear bomb or a conventional high-explosive bomb laced with radioactive materials". Successful "red teaming efforts" (friendly intrusion) to bring radioactive materials across domestic borders without detection is troublesome and recent red teaming efforts resulted in defeating storage protection for a number of the 1,200 healthcare based Cesium 137 within two minutes. Mobile vehicles equipped with radioactive materials for diagnostic and therapeutic healthcare purposes are often left unprotected and are attractive component parts for a detonate-in-place dirty bomb. Repeated accounts of loss, theft, and unexplained missing radioactive materials from Nuclear Plants and expended radioactive storage facilities add to the speculation that the availability of these materials to terrorist is a reality.

Documented accounts of relaxed security at research, diagnostic and therapeutic sites are seen as terrorist bomb opportunities at the site or theft of materials to be used at a time and location of their choosing. These conditions have many terrorism experts convinced that it is only a matter of time before these materials will be used in a future attack.

The Government Accountable Office (GAO) has been highly critical of the Nuclear Regulatory Commission's (NRC) oversight of nuclear research reactors located in University settings across the nation. Recent "red teaming" efforts have exposed the lack of security in hospitals and healthcare research organizations using radioactive materials in general and Cesium Chloride in particular. There are troubling questions about how these materials were protected, accounted for and disposed of during the recent Katrina and Ike storms. Recent testimony (GAO 12 512T) revealed serious gaps in security of this "1/2 of the dreaded Dirty Bomb".

Bioterrorism remains a major threat from both international terrorist and domestic extremists. Animal rights groups have aggressively attacked institutions using research animals while Earth Liberation and other environmental extremist groups have increased and pose serious threats to emerging nuclear and

biological WMD countermeasures. Management and Resources Information Sharing and Analysis Center (ERM-ISAC) infograms warn of the growing domestic extremist threats across the nation and US researchers have created a color-coded map that dramatically illustrates how American cities are vulnerable to bioterrorism. One hundred and thirty two (132) cities have been identified according to level of threat and vulnerability.

Lack of compliance with fundamental safety protocols has also resulted in a number of self-inflicted events leading to millions of dollars in fines and research program suspensions within the sector. Personal Protective Equipment (PPE) compliance remains high on the list of preparedness issues. Those organizations with appropriate numbers of PPE fail to maintain them in a readiness status, fail to drill and, in too many cases, do not have size mix in their inventories. There are also troubling concerns about dangers presented by abandoned bio-toxins and infected research animal tracking following recent disasters.

The nation is entering a window of increased risk for terrorist attacks. Congressional experts have expressed their concern over increased vulnerability to terrorist events during the transition of the Department of Homeland Security from this administration to the next, be they from either political party. Transitions are difficult at best and the additional stresses of an increasing hostile terrorism environment add complexity to an already complex undertaking. Foreign terrorists, among others, may see this hand-off period as their best opportunity to strike. This transition of Homeland Security functions must be seamless and characterized by uncommon goodwill and unusual dedication from all parties.

The initial lack of strong healthcare leadership in the new Department of Homeland Security and a seemingly indifferent non-federal healthcare sector set the stage for and contributed to the sector's weak involvement. The assumption, by some, that the Public Health sector and the established high profile, traditional "first responder community" (non-hospital EMS, Fire Fighters, law Enforcement), would take the lead and coordinate community planning with the non-federal healthcare provider sector was unfortunate. These groups did not aggressively reach-out to healthcare provider groups and the provider groups did not aggressively seek a place at the planning table.

Sector oversight has been weak from all existing mechanisms designed to accomplish that function, be they from governmental or private sources. The "wake-up" calls from 9/11 and Katrina were short lived. Immediately after each event there was a spirited advocacy for readiness followed by fading interest when federal funding would fall short of expected cost. There was a sudden burst of enthusiasm from organizations tasked with insuring quality and safety for the healthcare workplace. Objective signs of concern surfaced with the publication of reams of readiness guidance in endless detail which did not find its way into industry standards. The post-Katrina frenzy of activity surfaced old documents and renewed interest in healthcare readiness and "Lessons Learned" from that tragic experience. A full-scale, million dollar readiness exercise, "PAM", conducted a year before Katina, predicted using computer models a catastrophe almost identical to what actually happened including breached levees, number of citizens displaced, number of buildings flooded, etc.

The Disaster Mitigation Act (2000), an amendment to the Stafford Act, required states to identify and mitigate known vulnerabilities or face significant reduction in funding for losses which were deemed avoidable through proactive mitigation. States across the nation, including Louisiana, faithfully reported

compliance by 1 November 2004, signaling their readiness and receiving federal re-imbursement for mitigation.

Louisiana and New Orleans Hospitals and other healthcare organizations were Accredited or Certified that they were in compliance with CMS Conditions of Participation or its equivalence by proper oversight authority. Given all these assurances plus a three day alert indicating the path of the storm and its time of landfall, reason would lead one to believe that decision makers had the necessary information on which to make a "protect-in-place or evacuate" determination in case of an oncoming hurricane. Unfortunately, Lack of preparedness and poor decision-making at all levels of leadership reflect a wholesale failure of the sector to protect its most vulnerable charges.

The light at the end of the tunnel for a meaningful set of oversight standards for hospital emergency preparedness surfaced in June of 2007. The TJC (formally JCAHO) announced a series of revisions in its standards. The Joint Commission (TJC) has, until recently, held a virtual monopoly on the hospital industry's gateway to reimbursement for treatment of the eligible populations for the nation's federal healthcare programs, Medicare and Medicaid. The 2007 revisions, to be enforced in 2008, were profound and for the first time in the 21st century, hospitals would be required to meet standards that realistically positioned them to make informed decisions related to emergency management "protect in place or evacuate".

The revisions focused on six critical areas; Communications, Resources and assets, Safety and Security, Staff responsibilities, Utilities management, and Patient clinical and support activities. On April 17, 2008 The Joint Commission Accreditation Committee delayed accountability for the New Hospital Standards for Emergency Management (EM). Industry observers were stunned by the open admission from the field that they were not prepared for compliance and risked losing their accreditation if surveyed. The unprecedented TJC reversal of scoring standards, which they had so skillfully articulated during the previous year, does great harm to level of confidence in the creditability of legacy oversight functions. We believe that this Notice, relaxing the scoring of essential disaster preparedness elements sends the wrong message to our nation's hospitals.

The anti/counter terrorism community was surprised by active participation of U. K. physicians as suicide bombers/homicide bombers (SB/HBs). It was revealed that high ranking physicians have populated the terrorist ranks for decades, planning terrorist attacks and recruiting SB/HBs. Physicians and other healthcare caregivers are now seen as potential SB//HBs. International Medical Graduates (IMG) and heavily recruited nurses from Muslim countries pose a potentially challenging insider threat. The global reaction to these populations as possible terrorist threats produced a number of unexpected findings: International healthcare authorities were stunned by the magnitude of false information which surfaced as they intensified their background search of IMG's serving in their respective healthcare systems. The greater threat was to the patient populations who were exposed to healthcare procedures and treatment from less than qualified practitioners.

The Department of Homeland Security is in the process of auditing all H-1B visas for suspected error or fraud and estimates that as many as 20 percent contain fake degrees, forged qualifications and fictitious references. Early last year Puerto Rican authorities uncovered the illegal sale of Board Certification in Internal Medicine to eighty-eight IMG's.

Compounding this situation is the news release that the fastest growing source of illegal immigrants in

the U.S. is from INDIA, DHS places the number at 270,000 with the PEW Research Center estimate is over 400,000. Most enter the U.S. legally but violated terms of their visas.

The PEW Research Center May 22, 2007, Muslim-American Report concluded that there are 2.35 million Muslim-Americans in the United States. Surveyed on the issue, "can Suicide Bombing be justified?" Sixteen (16%) indicated that it would be justified in the defense of Islam. Among Muslims younger than 30 years of age Thirty (30%) indicated it was justified. Twenty-one percent of Muslim-Americans are African-Americans.

Recent reports from California have many in the business of assessing the industry for Homeland Security readiness asking serious question about the nation's resolve to address the all-hazards preparedness issue. Over half of California's hospitals have not complied with the state's Post-Northridge seismic upgrades and up to a third of the healthcare workforce have not been properly vetted for criminal or status backgrounds. As recently as July of 2008, the American Hospital Association questioned the need for all hospital employees' background searches.

The specter of a lone pregnant suicide bomber walking or wheeled into a hospital lobby or an ambulance, sirens blaring, with 500 pounds of explosives, or a stretch VIP limousine filled with unknown amounts of explosives salted with liberal amounts of radioactive materials pulling up to an un-reinforced, unprotected glass lobby entrance, or a lone unchallenged mortuary vehicle backing up to the morgue with a casket filled with explosives or a visiting IMG resident blowing himself up in a busy hospital cafeteria; any or all of these known threats should have the effect of concentrating one's mind on the wisdom of a return on investment (ROI) for all-hazards readiness including infrastructure protection.

None of these terrorist tactics are novel they have been employed world-wide by those who would do us harm. Those who are charged with the care and protection of our most vulnerable citizens, incapacitated by age, disease and/or injury (hospitalized) bear a heavy burden.

Emotional Reaction to catastrophic events is highly individual, whether induced by a destructive storm or a manmade assault. Alerts dealing with an approaching hurricane strike terror in those who may be in the path of the storm. Nebraska citizens may experience concern but rarely terror with an approaching hurricane in the gulf. A terrorist attack on a clustered Urban Medical Center located in anywhere USA within the nation - killing defenseless patients, caregivers and others in the wake of a simultaneous event - creates a Terror Multiplier Effect (TME).

The health facility may be a target of opportunity or a target in tandem with nearby high Value targets. The secondary effect of the destruction of a health facility is the denial of care to other victims in the area. Emergency care is redirected to healthcare facilities less prepared to respond to these events.

The 21st century is pregnant with unimagined advances in medical treatment and technology and promises for a healthier and longer lived citizenry. Closely shadowing that optimistic promise are dark and sinister forces dedicated to the destruction of that vision.

We have also seen the destructive forces of nature with random selection of targets for its wrath. According to some, natural disasters are becoming more frequent and more robust. Dealing with natural

disasters is challenging and in most cases the preparedness has been equal to the task. Most natural disasters come with advanced warnings. In some cases little warning and in some cases, earthquakes, none, but when they happen they are recognized as what they are. Terrorist attacks (CBRNE) come without warning and in the case of bioterrorism there may be a considerable delay before it is recognized. The recent Mumbai attack was a sobering event. A small group of terrorists with conventional weapons were able to paralyze a city for three days and kill or wound hundreds of citizens. A hospital was attacked during the event, the third Indian hospital to be attacked in 2008.

It is incumbent on all segments of the healthcare industry to become full partners in the nation's strategy for all-hazards protection. The industry cannot afford another systemic failure in responding to known threats. The many human and organizational decisions embodied in effectively responding to the complex requirement for all-hazards preparedness must be made before disasters hits.

The requirement for hospitals to be prepare for and respond to natural disasters has been "on the books" since the early "Hill-Burton" days. The early days of the Cold War found hospitals prepared to survive in place or evacuate to a safer location if nuclear fall-out permitted. Survival in place was not a matter of hours or weeks; it often called for months in place. Evacuation to an alternate site was a highly coordinated effort; over-subscription of resources to execute the effort was unknown. Readiness was not an adjunct to other concerns; it was an important day–to-day activity, an integral part of the mission.

Guidance for the possibility of the use of weapons of mass destruction (WMD) by terrorist emerged in the late 80s. Executive Orders directed federal agencies to prepare for a possible WMD terrorist attack. Federal Health Agencies were under Congressional mandates to prepare for these events, the non-federal sector was expected to partner through voluntary initiatives.

Many expected the non-federal healthcare sector, armed with its existing natural hazards and CBRNE accidents based disaster plans, would move forward and work on the margins to satisfy the preparedness requirements associated with these emerging threats.

It sounded reasonable at the time, unfortunately over-time the degradation of the readiness mission left preparedness and response gaps which required more than work on the margins.

Additionally, the Base Realignment and Closure Commission (BRAC, 2005) will have a significant impact on the non-federal healthcare sector. Defense officials have used the BRAC to transform the way military medicine operates. The closure of a significant number of Department of Defense (DOD) hospitals will create an increased dependence on non-federal hospitals for the care and treatment of both active and retired DOD beneficiaries. The full impact of this transformation has not been experienced. The DOD is still recovering from the Walter Reed scandal and has been sensitized to the need to insure that "those who have borne the battle" receive the same level of care and same level of security as that enjoyed in military treatment facilities.

One of the great ironies posed by the nation's zeal to care for "Wounded Warriors" is that "Operation Mend" places these patients in non-federal hospitals in urban areas which fail to provide for any measure of protection from outside or inside terrorism.

The greatest disparity in non-federal all- hazards readiness exists between the trusting public's

perception of the industry's protection and the reality that it is not there.

A decade after the 9/11 terrorist attack the non-federal healthcare sector is ill prepared to protect its charges. It takes more than an apathetic healthcare industry to fail a trusting public. Enablers come from many quarters, sins of commission abound. Sins of omission take less courage and are far more harmful to the common good.

## August 2014 Update

Very little has changed in subsequent years related to many of the issues raised in this White Paper. From an All Hazards perspective, there have been some important events we will cover in subsequent paragraphs, but generally speaking the perennial challenges of All Hazards readiness have not been addressed to bring the Healthcare Sector in line with its' expected role in the National Response Framework (NRF). In the wake of Super Storm Sandy, Centers for Medicare and Medicaid (CMS) introduced new regulations (CMS-3178-P) which mandate Emergency Readiness standards for the Healthcare Sector using an All Hazards approach. Many in the industry see this new regulation as similar to the CFATS regulations mandated in the Chemical Sector after many years of unsuccessfully relying on voluntary compliance for Safety and Security aspects in that industry sector. Starting with the H1N1 Flu Season we can separate the important All Hazards topics and discuss major events since 2009:

### Unprepared for Biological Threats

During the H1N1 season, we wrote about lack of general lack of readiness to surge in case of a major pandemic, including the estimate that most of the mechanical ventilators (70% - 80%) were in already use at the time the wave came through, and that serious questions remain in terms of guidance for priority allocation of medicine and limited medical equipment and supplies. For example, in New York State's guidance:

"Although New York State continues to purchase and stockpile ventilators as part of our pandemic preparedness, we know that if a severe pandemic occurs, shortages are inevitable," Acting New York State Health Commissioner Richard F. Daines, M.D. said. "We must plan ahead to ensure that decisions to triage ventilators will be fair, and will benefit as many patients as possible."

"The ventilator policy would take effect in the event of a severe pandemic – such as the 1918 "Spanish Flu" – resulting in a critical shortage of the breathing devices and staff to operate them. It calls for clinicians to evaluate patients based on objective, universally applied medical criteria. Non-clinical factors such as race, ethnicity, socio-economic status, perceived quality of life or ability to pay would not be weighed in the decision-making process."

This all sounds good, however, in the same month we had pronouncements from CDC that seem to contradict this guidance, suggesting that children and their caregivers were more susceptible to H1N1 and should get priority vaccinations:

"Children aged <5 years or with certain chronic medical conditions are at increased risk for complications and death from influenza (*1--3*). Because of this increased risk, the Advisory Committee on Immunization Practices (ACIP) has prioritized influenza prevention and treatment for children aged <5 years and for those with certain chronic medical and immunosuppressive conditions (*4*,*5*)."

Another segment of the population (cohort) is federal prisoners, who also have special needs and have guidance of their own, according to CDC:

"Correctional institutions pose special risks and considerations due to the nature of their unique environment. Inmates are in mandatory custody and options are limited for isolation and removal of ill persons from the environment. The workforce must be maintained and options are limited for work alternatives (e.g., work from home, reduced or alternate schedules, etc.). In addition, many inmates and workforce may have medical conditions that increase their risk of influenza-related complications. The focus of this guidance is on general preventive measures for institutions, risk reduction of introduction of the virus into institutions, rapid detection of persons with novel influenza A (H1N1) infections, and management and isolation of identified cases."

In summary, for the H1N1 season of 2009, we had spent billions of dollars implementing the recommendations from the 9/11 Commission to mitigate the threats of biological agents and pandemic, however the H1N1 virus moved from Mexico City to Canada before we had even identified the strain, many hospitals did not have pandemic plans in place, there was a shortage of vaccine and it had to be rationed. As the country responded to the threat, guidance from authorities was contradictory related to which groups of the population, if any, should receive vaccination or priority treatment.

**Publication of UNREADY- TO ERR IS HUMAN**

In 2010 We published our first book, UNREADY- TO ERR IS HUMAN: The Other Neglected Side of Hospital Safety and Security, a critical review the Healthcare Sector's Public and Private partnership that most Americans believe is prepared to react to All Hazards events such as the increasing frequency and severity of natural disasters, the likelihood of a pandemic due to bio-error or bio-terror, and the increasingly frequent linking to hospitals as "soft targets" for international terrorism. This comprehensive investigation uncovers some shocking vulnerabilities. The book is laid out in chapters covering the myths and realities of the American Healthcare Sector, including myths concerning Overall Industry Readiness and Readiness in the areas of Pandemic, Terrorist threats, Hospital Safety, Workplace Violence, Urban and Rural differences, etc. The book has been used to develop a graduate-level seminar presentation to instruct both Hospital Administration and Nursing Graduate Students and for Safety and Security Seminars for State Emergency Operations professionals.

**Publication of Deadly Neglect: Apathy & Denial vs. Act of God**

In 2011, we published our second book titled Deadly Neglect**:** Apathy & Denial vs. Act of God, based on the doctoral dissertation of Dr. Marti Jordan's account of a brave group of nurses who lived through a post Hurricane Katrina nightmare scenario that is almost unbelievable – No food, water, electricity, advanced medical equipment, plumbing, back-up generators flooded. Makeshift morgues without air conditioning for almost two weeks, Gangs roaming the hospitals trying to get into the Pharmacies,

patients and their families stressed to the breaking point over increasingly scarce resources, gunshots coming into the hospital, sharks swimming in the parking lots and giant nutria rats trying to get to high ground wherever they could. Based on the confidential testimony of nine nurses who lived through the tragedy, this true life account of survival during a total lack of security is a testament to what can happen the fabric of society unravels and people are forced to completely fend for themselves. A graduate-level seminar presentation has been prepared and delivered to Hospital Administration and Nursing Graduate Students and other professional organizations.

### Joplin Tornado Lack of Readiness

On May 22, 2011 an F5 Tornado smashed through Joplin Missouri, taking over 160 lives and causing over 1,100 casualties and $2.8B in property damage to the community, including the destruction of St. John's Regional Medical Center, a major healthcare facility serving the area, where fifteen lives were lost. In a separate location, 21 lives were lost at the Greenbriar Nursing Home. Later analysis by the New York Times suggested that there was adequate warning of the coming tornado, but the reaction of the public was dampened by a lack of confidence due to a "cry wolf" attitude and confusion as to the exact threat signaled by the sirens. Subsequent research by CHCER revealed that the County Emergency Management plans were inadequate to respond to the event and there had been no coordination between the Greenbrier and Emergency Management officials at the City and County levels.

### Seven Years after Katrina - Still Not Ready for Hurricanes

In what turned out to be one of the most expensive Natural Disasters in US history, Hurricane Sandy cost 258 lives and caused $68B in damages. The storm was tracked from August 22 on a steady course for New England and New York with dire warnings of record flooding predicted several days in advance. The record flooding did come and overwhelmed several hospitals in Manhattan with flooded lower levels. Despite the Sandy warnings, the decision by local government was to Protect in Place, the same decision made in New Orleans as Katrina approached. As in Katrina, the most vulnerable equipment was the back-up generators and electrical system that failed. In the cases of Langone Medical Center and Belleview Hospital Center, flooded emergency generators forced the chaotic evacuation of the most fragile patients through darkened and flooded stairwells.

### Rapid Growth of US Biolabs and Emerging Biological Threats

In a scathing report in 2009, **GAO-09-1036T**, found that there was a serious lack of oversight in the biological testing laboratories that proliferated in the wake of the Anthrax terror event in 2001. Among the findings:

"Because no federal agency has the mission to track the expansion of BSL-3 and BSL-4 laboratories in the United States, no federal agency knows how many such laboratories exist in the United States. While there is a consensus among federal agency officials and experts that some degree of risk is always associated with high-containment laboratories, ***no one agency is responsible for determining, or able to determine, the aggregate or cumulative risks associated with the expansion*** of these high-containment laboratories."

- "Four highly publicized incidents in high-containment laboratories, as well as evidence in the scientific literature, demonstrate that:

  (1) While laboratory accidents are rare, they do occur, primarily because of human error or systems (management and technical operations) failure, including the failure of safety equipment and procedures;

  (2) Insiders can pose a risk; and

  (3) It is difficult to control inventories of biological agents with currently available technologies. It has been suggested that personnel reliability programs would mitigate the insider risk. The National Science Advisory Board for Biosecurity reported that there is little evidence that personnel reliability measures are effective or have predictive value in identifying individuals who may pose an insider risk.

  (4) Continuity of electrical power is vital for the safe functioning of high-containment laboratories; in particular since maintenance of essential pressure differentials using electrically driven fans provides an important barrier for preventing the uncontrolled release of agents. 65 Lapses in electrical power that occurred at a CDC laboratory raise concerns about standards in high-containment laboratory facility design, management of construction, and operations."

Despite the report, very little was done to address the safety concerns, and in 2011 there were public protests in Boston by concerned citizens, as **reported** by ABC News.

The GAO released a second report, **GAO-13-844R**, again raising a red flag in February 2013, expressing concern that none of the recommendations in the original report had been acted upon, and the number of unregulated labs had increased significantly during the interim. This finally got the attention of the Department of Homeland Security in a **news story** in April of 2013.

We are in an increasingly dangerous environment due to several factors:

**The Availability of Medicine** - Profiteers in the national drug distribution system have created a **Grey Market/Black Market** based on "purchasing" drugs (without physically taking possession) and reselling them several times, in some cases driving the price up 8,000% between factory and end user organization, and creating false shortages in supply. This in combination with having a large percentage of medicines, including basic vaccines, manufactured offshore (China) puts the nation in a strategically weak position to ensure **availability, authenticity and quality** of imported drugs. Theft within the distribution channel has also increased dramatically, particularly among the opioids, which have helped drive an epidemic of addiction to Oxycontin and Oxycodone; which is in turn part of a larger, broad-based heroin **explosion** across the country.

**Number and Location of Biolabs**: Some major Bio-containment and Biosecurity Level-3 (BSL-3) and Biosecurity Level-4 (BSL-4) labs are in dangerous locations. For example, prior to Hurricane Katrina, Tulane National Primate Research Center had over 5,000 monkeys and apes in a cluster of BSL-3 facilities; mostly in outdoor cages. As evidenced by the exploding population of Burmese Pythons in the

Everglades from private containment facilities, animals have a way of escaping when the buildings are destroyed in a hurricane.

Galveston Texas houses a BSL-4 facility, one of the two National Laboratories, and serves as the Western Regional Center of Excellence for Biodefense and Emerging Infectious Diseases. Galveston is also the location of the deadliest weather disaster in United States history, the Hurricane of 1900 that took between 6,000 and 12,000 lives, with 12 foot low-tide surges flooding 6–10 miles inland. Since 1983 Galveston has suffered three billion-dollar hurricanes, Alicia in 1983 with $2B, Allison in 2001 with $5B, and Hurricane Ike in 2008 with $29.5B in US damage. The UT labs have been completely devastated due to flooding several times. It would be hard to choose a more dangerous location.

**Bio-Errors**: According to a recent **USA TODAY** article, over 1,100 safety incidents were reported by US labs, both government and private:

"Data for incidents reported in 2013 is not yet finalized, CDC said. In 2012, lab regulators received 247 reports of potential releases of dangerous pathogens. They also received 247 reports in 2011. There were 275 reports in 2010; 243 in 2009; and 116 in 2008. The reports come from regulated select agent research labs as well as clinical or diagnostic labs that are exempted from registration with federal officials but still must report incidents if they identify a select agent."

Hospitals and other providers responsible to offer care in a biological event should have minimum levels of information about what specific bio agents "select agents" are being studied in the area in order to provide an earlier diagnosis if a patient presents with flu-like or agent-specific symptoms.

Our objective is only to draw attention to what appears to be an increasing and unchecked threat from biological events, the danger posed by accidental exposure in an unregulated environment or intentional public release from an insider who should not have access to these materials is truly a cause for concern. At a minimum, the Federal government needs to get serious about the thousands of unregulated labs.

## Recent Large-Scale Biological Events

**SARS**: On April 16, 2014, over 2,000 vials of the deadly SARS virus **disappeared** from the Pasteur Institute Laboratory in France.

**EBOLA**: The largest and most dangerous **Ebola Outbreak** continues to spread like an approaching slow-motion train wreck through West Africa, reaching to over 3,000 confirmed cases and 1,552 fatalities between February and August of 2014, with no end in sight. More on this at the end of this document.

**AVIAN FLU**: Japanese Self Defense forces were enlisted to cull over **100,000 chickens** on April 13, 2014, after a hundred birds died the previous weekend.

**MERS**: We **predicted** that the pilgrims coming into Saudi Arabia and then returning to their home countries by air would be a vector for the disease in 2013. This seems to be the case for at least one death in Malaysia, as **reported** by the Wall Street Journal.

### The 2014 Umrah and Haj season

The annual Hajj pilgrimage to Mecca, Saudi Arabia, is among the largest mass gatherings in the world. Hajj draws about 3 million Muslims from around the world, and more than 11,000 Americans make the pilgrimage each year. This year, Hajj will take place from approximately October 2–7, 2014. Umrah is a similar pilgrimage that can be undertaken at any time of the year.

The Saudi government has instituted a policy of limiting visas for 15 days for pilgrims this year, and is also making recommendations for the following groups postpone their travel:

- People older than 65 years
- Children younger than 12 years
- Pregnant women
- People with chronic diseases (such as heart disease, kidney disease, diabetes, or respiratory disease)
- People with weakened immune systems or who take drugs that suppress the immune system
- People with cancer or terminal illness
- On the heels of a suspected case of Ebola in Jeddah, Saudi officials announced they would not issue Umrah or Hajj visas for people coming from Liberia, Sierra Leone or Guinea this year.

**TB and Diabetes Comorbidity**: According to the World Health Organization **website**: "Along the US-Mexico border, the incidence of TB is 7.9 per 100,000 population in US border states and 26.3 per 100,000 population in Mexican border states, both of which are higher than the national averages in the US and Mexico, respectively. Diabetes is a major problem along the US-Mexico border. In 2003, diabetes was the third leading cause of death on the Mexican side of the border, and the sixth on the US side. Recent prevalence estimates indicate that approximately 16% of the people living along the border have diabetes, and another 14% of adults on the US side have pre-diabetes. Recent evidence found that TB-diabetes comorbidity exceeded that of comorbidity with HIV/AIDS".

## Hospital Safety and Security

There is a difference between clinical safety and physical safety and this difference is neither understood nor acknowledged by the trade publications that create lists – and run advertisements of- the "Best" hospitals. The lack of Clinical Safety and the shoddy survey methodology make us wonder why they produce the lists in the first place – they do not provide accurate information to patients that helps them decide on the best hospitals to receive care.

## Clinical Safety: Medical Errors Continue to Claim Hundreds of Thousands of Lives Annually

One major fact that deserves a lot more public scrutiny is that Hospitals are not safe places in general; hundreds of thousands of patients die each year, and the situation is getting worse, not better. Patients turn to ratings by respected publications for guidance about safe and quality care; by using these ratings to quell concerns about safety, the public health and healthcare sector obfuscates the true level of safety and security, and perpetuates the myth of quality care and readiness, while the sector remains the weakest link in the Homeland Security Chain.

Looking at a top five list of "best" hospitals, clinical quality of care is assumed to be provided, although in practice it cannot be a given when faced with estimates of hundreds of thousands of deaths due to medical errors, first examined in the shocking IOM report in 1999, **To Err is Human**. Ten years on, Consumer's Union published their report, "**To Err is Human, To Delay is Deadly**" which showed that very little had changed despite the alarms raised and the industry promises to reduce the number of preventable deaths. Fifteen years on, the estimate has risen to over 440,000 preventable deaths according to a Journal of Patient Safety study. As quoted from a well-written **2013 Forbes article**:

"The reason many hospital leaders fail to put a priority on safety is that we as a country haven't forced them to do so. On the contrary, we haplessly pay them for these errors. We tolerate hospital lobbyists **insisting on hiding their error rates**. We fail to insist on safety when we choose where to seek care or when we put together our business' **health benefits**. When we don't demand safety, they don't supply it."

Recent events also demonstrate that it is not only the Ranking Organizations that can hide the reality from an uninformed public; according to his Senate testimony after resigning as **VA Secretary, General Shinseki** noted that the Congress' own monopoly watchdog, the Joint Commission (TJC), had been consistently (30 years+) giving the VA Health System high marks and even Top Ratings for the care provided, despite several scandals that suggested otherwise. The recent VA scandal turned out to be a major surprise to many, but we know from our research that Congress has a steady stream of complaints coming in from veterans at the end of their rope, and staffers call individual VA hospitals regularly to intervene. As seen by the numbers above, VA may be the tip of the iceberg when it comes to assessing the quality of care and safety of patients in all US hospitals.

## The Ranking Methodology is Flawed and Self-Serving

While reviewing **our latest article** published in the June/July Homeland Security Today, and the excellent companion piece by Peter Marghella, we were reminded about how self-serving and misleading the nation's Hospital Ranking entities have become in selecting a facility for safe, quality care.

Last year we did a series of articles on the subject of hospital rankings, and although RTI (US News' research contractor) conceded on some issues of methodology; removing some of the most subjective and self-serving criteria for ranking hospitals, the methodology is flawed and does not accurately represent anything that will help PATIENTS make better decisions based on ACCESS, QUALITY and COST of care, which are the foundational components of an effective healthcare system. These rankings are a thinly-veiled marketing tool for the hospitals to claim they do a better job than competitors. A good

example is covered in this **post**, which discusses how Langone Medical Center in New York City managed to turn the failure to prepare for Super storm Sandy into a public relations win and millions more in subsidies.

A deeper and more critical look at the methodologies of ranking, who benefits and whether they are useful followed in this **post**, which cited very good analysis from HANYS (Hospital Association of New York State), as they tried to untangle fact from fiction and stress test the methodologies offered by the most vocal and visible survey providers in the market.

Among the important recommendations for improvement in this survey of surveyors, methodology, data quality and data comparability issues came to the top:

1. A transparent methodology;
2. Evidence-based measures;
3. Measure alignment;
4. Appropriate data source;
5. Most current data;
6. Risk-adjusted data;
7. Data quality;
8. Consistent data; and
9. Hospital preview.

**KEY RECOMMENDATION**

"HANYS supports the availability of hospital quality and safety information to help patients make choices and assist providers in improving care. However, the information must be based on a standard set of measures that have been proven to be valid, reliable, and evidence-based."

We agree with most of these recommendations but would also like to see other criteria included for selection of top hospitals.

**PAY TO PLAY AND SELECTIVE INCLUSION**

A recent RAND Corporation Study also came out with some interesting points concerning the US News methodology and conclusions, commenting that more expensive hospitals were more likely to be rated higher than those who were in the mid-range or low-range, despite worse outcomes for the more expensive facilities on some key quality metrics including readmission rates. This is not so surprising if we consider that hospitals are required to pay US News to use the logo in advertising, as in the case of Children's Mercy Hospitals, who paid $42,000 for the US News stamp of approval in their ads. Clearly, this kind of conflict of interest negates any semblance of an impartial survey process. This is only one example from one survey and there are many more…

## Other Factors That Could Be Measured That DO Impact Patient Safety and Quality

## What is missing? – Safety and Security of the Facility

In our opinion, all of the methodologies we have seen lack the inclusion of a measure on the physical safety and security of the facility. Evidence shows that in Katrina, Allison and Sandy, without access to the life-sustaining plant and equipment, it does not matter what care is onsite, because it all becomes useless. The failure to prepare for known hazards (based on climate, geography and geopolitics) can essentially deny care to ALL patients in the blink of an eye when capacity and capability to provide care are devastated. Meeting the three elements of care; Access, Quality and Cost, can be neutralized by a single shift in a seismic plate, tornado, derecho, hurricane, or other All Hazards event. Not integrating this safety factor into the ranking methodology is a major failure in protecting all stakeholders.

### What is missing? – Social Obligations

Healthcare is a very opaque environment and the general public does not understand how likely hospitals and other care providers are to put their own interests above patients; how many customers would continue to visit an auto mechanic who uses counterfeit parts and charges premium prices, loses control of customer credit card data, and cheats on taxes?

While we do understand the complexity of the business environment and pressure to contain costs, we have to ask whether a hospital should be considered among the top rated if it has participated in blatantly illegal and uncivil behavior; multiple fines for fraud and abuse, loss of personally identifiable health information, failure to report major errors, illegal hiring practices, failure to adequately protect employees from workplace hazards, failure to take reasonable measures to stem the rising tide of workplace violence, especially among women caregivers. Do they even deserve our business, much less a Best Hospital rating?

While the bottom line of the organization is critically important to viability, the steady erosion of these social factors in favor of profit, rising prices and outrageous salaries has distanced hospitals from the patient. In the end, it should be the patients looking for quality and safe care, not the hospitals looking for an advertising edge, who benefit from the research into the top-rated hospitals.

### Workplace Violence Continues Unabated

Originally published in our book “Unready: To err is human – the other neglected side of Hospital Safety and Security” July, 2010 and as relevant four years later as it was on day one.

Two stabbings in separate UCLA hospitals occurred this week in California, leaving one Nurse in critical condition, which brought our attention back to this issue. There is an update at the end of the post.

**Myth**: Hospital Stakeholders are Safe and Secure in their Hospitals.

**Reality**: Hospitals are very dangerous places for all employees, in general, and women in particular. The risk of being in an unhealthy environment does not stop with exposure to a whole range of diseases. Female healthcare employees are counted among the most physically assaulted workers in the American workforce.

Violence in hospitals is viewed as a multidimensional problem and the level of it in the nation's emergency departments has risen unabated over the last decade. Hospital's emergency departments are the hospital's "window to the world" and the door through which some of the most anxious and fearful populations enter.

The triage process makes a lot of sense to those engaged in the activity, but often it is not commonly understood nor appreciated by patient populations. Increased overcrowding and long waits for treatment elicit strong emotional responses from patients and their families. Even with adequately staffed, skilled security personnel and sufficient numbers of experienced caregivers, treatment sites get overwhelmed.

The lack of available beds for timely admissions for seriously ill patients leads to frustration, and families may lash out at caregivers or become behavioral problems themselves. Many walk-in patients have chronic mental health problems and are often disruptive, loud and aggressive. Gang-related shootings may bring in both the shooters and the victims. Add the ever-present "forensic patient," who may be a danger to himself or others, with police escort and who also may be a flight risk. Escort officers may or may not be experienced and are often inattentive. Under the category of "no good deed goes unpunished," anecdotal reports are starting to surface from healthcare organizations that uninsured patients are showing up at physicians' offices and emergency rooms demanding care, now that the healthcare reform bill has been signed into law.

Weapons of every type and description find their way into these treatment sites. Design and construction of facilities do much to mitigate problems associated with space and segregation of unruly patients. Metal detectors are in use by many hospitals across the nation. Hospital authorities are reluctant to employ these proven tools in the fight against violence out of concern for symbolic appearances of an unsafe environment for customers. Security officials find it a hard sell.

One hospital security official tells of a situation where he convinced his executive suite to try a temporary metal detector only at the emergency room entrance. The first month's yield of weapons was more than 500. They included firearms, knives, razors, pepper spray, and an assorted number of items which were designed to inflict harm. Needless to say, metal detectors were to be a permanent fixture in a number of places on this campus.

When interviewing caregivers about "violence in hospitals," the emergency department is generally first to be mentioned. Incident reports tell a broader story. Verbal abuse is recorded from all locations in the hospital; however, physical abuse is always under-reported. One-on-one encounters without witnesses are difficult to judge. Violence between and among coworkers is on the rise. One narrow point in the funnel is Human Resources and a comprehensive criminal background check policy. A recent statewide study of background checks for healthcare workers revealed that one-third of the state's caregivers did not have a criminal background check at the time of employment. The unsettling aspect of this population is that they were caregivers with close person-to-person patient contact relationships; 75% of all psychiatric technicians, 50% of all family therapists, social workers and dentists, and 12% of all physicians.

We now turn to patients as victims of violence from caregivers. One startling report covering the period 1970 to 2006 identified 54 caregivers responsible for over 2,100 deaths. Caregivers who are serial killers have been able to move from hospital to hospital with relative ease. Obviously, the importance of identifying and reporting these offenders should be an organizational priority. One well-intended step taken by the healthcare industry has been to inform the federal government when they take action against dangerous caregivers. The value of having a central registry to protect vulnerable patients across the nation speaks for itself.

The Department of Health and Human Services revealed that its two decade-old national database listing the names of those who were reported as offenders (nurses, pharmacists, psychologists, other healthcare professionals) across the nation "is missing." It provides little comfort to know that they will reconstitute the list as soon as possible. To err is human, but what are the consequences?

### April 2014 Update

A recent study shows that little progress has been made over the last few years and if anything, we are sliding backwards as more assaults, **active shooter events** make the hospital a more dangerous place.

"Assaults on emergency nurses have lasting impacts on the nurses and the ability of emergency care facilities to provide quality care," said 2014 Emergency Nurses Association (ENA) President Deena Brecher, MSN, RN, APN, ACNS-BC, CEN, CPEN. According to the Bureau of Labor Statistics, assault on a healthcare worker is the most common reason for non-fatal injuries or illness requiring days off from work.

"More than 70% of emergency nurses reported physical or verbal assaults by patients or visitors while they were providing care. As a result, we lose experienced and dedicated nurses to physical or psychological trauma for days or sometimes permanently. Healthcare organizations have a responsibility to nurses and the public to provide a safe and secure environment."

The study places onus on the healthcare organizations to improve training and education, make environmental modifications and take stronger approach to law enforcement. There are many direct quotes from first hand victims **here,** a video interview can be seen **here.**

### Mass Casualties from Civil Unrest

In the Ferguson, Missouri case of an unarmed black teenager killed by a white police officer, we have seen how quickly tensions can boil over; escalating from a small group of protesters to a full blown riot in the space of a few hours, and even minutes. Politics aside, the first lesson here is that this kind of thing unfortunately can happen anywhere, urban or suburban. The second is that mass casualties can result very quickly, ranging from respiratory irritation to contusions, to burns, to gunshot wounds. As usual from a healthcare security perspective, the most dangerous place in the hospital is the Emergency Department; it is surging and starting to overflow with visitors. In this scenario, we imagine casualties coming into the hospital from both the community and law enforcement, along with family members and other visitors. Immediate questions that come to mind include:

- What is the Access Control Protocol? Parking Lot and Perimeter visitor surge?
- Will visitors be segregated?
- How can we prevent weapons from coming into the hospital during the surge?
- Roles and Responsibilities for physical security in the ED – employees and contractors?
- What triage protocol will be followed? Who will explain it to those whose family members are in line for care?

While these challenges are not new, they are very timely for two important reasons: The first is that we have probably yet to see the peak of unrest in St. Louis County Mo., and the second is that **new CMS regulations** that will mandate Emergency Preparedness Standards for all service providers who seek reimbursement from Medicare and Medicaid.

## What Happens Next in Ferguson?

We mentioned above how quickly things can escalate on the ground. As the next steps in the legal process unfold in St. Louis, there is a high probability for violent demonstrations and quick law enforcement response regardless of the outcomes. Two obvious flashpoints, not limited to St. Louis, are the grand jury decisions to indict or not to indict, and if indicted, the ruling of the jury.

There is a window of opportunity for the healthcare community to begin preparing for this known threat. Both Defense and Prosecution will delay the Grand Jury to gather additional information to meet their objectives. For example, a toxicology report may or may not be used, although information selectively leaked to the press suggests that Michael Brown had marijuana in his system.

In terms of community tension and managing the crisis from a communications perspective, the authorities have fanned the flames by not being transparent in all details of the case. For example, if the officer was attacked and seriously beaten by the 6'3, 300 lb. teenager as some rumors suggest, why hasn't that come to light? We know a crime scene investigation is required but why was Michael Brown's body not transported by an ambulance and why not sooner after the shooting? And what is the actual chronology of the alleged strong-arm robbery and the radio call to the field; was the officer responding to a legitimate description from the robbery? As we can see, all of these natural questions work in favor of the victim because without information, the narrative begins to take on a life of its' own and the community agitates for more information, resulting in escalating violence and ultimately forcing the top law enforcement official in the nation to make a personal appearance to calm things down and reassure the public that justice and accountability will prevail. There is a lesson here about crisis communications and lack of transparency; the longer you take responding to an escalating event, the more likely that (even good) arguments will be dismissed and be insufficient to calm public opinion.

## Are Hospitals Prepared for the Worst?

Back to the point, there are at least two more flashpoints here: The Grand Jury findings and the jury verdict for the police officer, if there is a trial. The grand jury in this racially-charged situation is comprised of 9 Caucasians and 3 African Americans, appointed by the local District Attorney, who has been portrayed by many Ferguson residents as being **biased for personal reasons**, according to the New York Times.

Our question is whether the local hospital systems have the Emergency Plans and situational awareness to respond appropriately to the civil unrest that will almost certainly break out regardless of these outcomes. Another simmering issue here is that Missouri law allows for law enforcement to **respond with deadly force** during the commission of a felony crime, according to the Washington Post. Add to this volatile mix, the opportunity for agitators to come in to Ferguson with the express purpose of shooting a cop during the next gathering after authorities make the Grand Jury announcement. This is a spark that could cause a nationwide explosion of unrest, and it could come just as easily from an external terrorist organization as from those in the community or from another state.

The clock is ticking on both of these pending legal decisions – it is reasonable to ask how the large hospitals in the Ferguson area have updated the Emergency Management and Operations Plans to account for these known threats. Given the lack of information made public, it is very difficult to predict what will happen, but we can be reasonably sure that it is going to be a long summer in Ferguson.

## The 2014 Veteran's Administration Scandal

Veterans Administration Secretary General Shinseki resigned his position on May 30th, 2014, after a meeting with the President, according to this Washington Post **report**, falling on his sword to eliminate distractions as the VA scrambled to fix widespread failures to provide timely care to veterans.

With the hindsight of being an old soldier who has been deeply involved with the DoD and VHA healthcare systems for over forty years, both as a senior Army Healthcare Administrator and a Combat-Wounded veteran, the recent scandal does not really come as a surprise; there were many warning signs over the past ten years. It was a surprise that those at the top of the organization could be unaware of the long-standing problems that so many veterans face getting access to continued care.

That General Shinseki is an extraordinary patriot is undeniable; West Point graduate from poor second-generation immigrant family, first Asian American four-star General, the first Asian American in several High-level Military and government positions, including his latest as VA Secretary. That he has served bravely is also without doubt; on the field in Vietnam he came through the 95th Combat Evacuation hospital, coincidently at the time when I had the honor to serve there as the Executive Officer, and in the political arena, the courage to speak truth to power, warning that the Administration "plan" to pacify Iraq was inadequate and would require years and over a hundred thousand troops on the ground, which cost him his job. His position was later vindicated as troop levels grew annually until they peaked at around 158,000 in 2008, following several years of failure to contain the growing insurgency and religious civil war.

There have been hundreds of hours of talking head commentaries about the scandal on all the news channels and outlets. It is surprising that while there is criticism flowing in from both sides of the aisle in Congress, some key questions concerning oversight have not been asked, including:

1) Were there warning signs about serious problems in the intake and continuity of care?

2) Who is responsible for oversight?

3) How can oversight be improved in the future?

## 1. Were there warning signs about serious problems in the intake and continuity of care?

### Previous Scandal and OIG Warnings

As we watched this problem unfold, it brought to mind the widely reported 2007 **Walter Reed scandal**, which resulted in the Secretary of the Army's resignation as well as the replacement of the commanding officer and several others at Walter Reed Army Medical Center. At the time, Congressional members also spoke out with indignation, crying for blood and promising to fix the system, and then went quiet.

The Office of the Inspector General (OIG) has produced 18 reports since 2005, according to this **USA Today article**:

"The Inspector General's Office (OIG) said the problems it is finding are not new. It has issued 18 reports dating to 2005, documenting delays in treating veterans at some of the agency's 150 hospitals and 820 clinics and detrimental health impact these delays have had on these patients."

The VA **budget** shows a $121 million line item allocated to the OIG in 2015. These reports are produced as a management tool and should be used to improve healthcare access, quality and cost for veterans. They are meant to be a neutral assessment of how the organization is performing, providing an unbiased view that should probably be taken more seriously given the resources to produce them. Because the final reports come out several months or even years after the research and everyone is aware of the major findings, it is common that hospitals respond that they have already fixed the deficiencies and they wait until the next inspection to fix the issues, if they do at all.

### The White House Should Have Known

The White House also had plenty of opportunities to identify and address the brewing problems; as revealed in this hard-hitting Washington Times May 21 **Report**:

"According to the documents, the VA inspector general told the Obama transition team of three audits dating back to 2005 that revealed significant problems with wait times and scheduling.

One of those audits showed an instance in which the department reported 2,900 veterans waited more than a month for medical appointments. The actual figure was closer to 28,000 veterans, according to the auditors."

Also, it should be highlighted that **Senator Barack Obama** sat on the US Senate Committee on Veterans Affairs, during his short tenure in the US Senate.

### Internal VHA Mechanisms Failed at Every Level

Reading through the above USA Today article, it is pretty clear that the internal mechanisms for measuring performance are broken or being manipulated for compensation reasons, and maybe they

are measuring the wrong things altogether; incentives around the speed of turnaround times and volume of care delivered are quickly being replaced as the industry moves to measure quality of care with increased accountability and affordability.

Without minimizing the failure of the senior leadership to address the obvious problems (at least to those outside the organization), there were serious issues in process, systems, training and communication that all impacted the VA's ability to deliver timely care. However, there are no credible excuses to explain the apparent lack of awareness on the part of senior officials.

As with most of these types of scandals, it boils down to ignorance or complicity, neither of which is acceptable when hundreds of billions in taxpayer dollars have been provided for the best treatment possible.

## External VHA Performance Measurement Mechanisms

### Mixed Messages

Other External Evaluations include those required for accreditation and certification, the most important being the Joint Commission (TJC), which has enjoyed a longstanding congressionally mandated quasi-monopoly to accredit VHA hospitals. Whether this monopoly has been a detriment or benefit is debatable, what is not is that TJC listed the Phoenix VA Medical System first on their list of highest performers in 2010, an accolade which was quoted by the Secretary in the following Press Release:

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FOR IMMEDIATE RELEASE

September 14, 2011

**Twenty VA Medical Centers Make The Joint Commission's Top Performers List**

WASHINGTON – Twenty Department of Veterans Affairs (VA) medical centers from across the Nation were recognized by The Joint Commission today as Top Performers on Key Quality Measures for 2010.

*"We at VA are very pleased with the recognition from The Joint Commission. We are proud of the medical centers that made this list, proving VA's commitment to performance measures, transparency, and accountability," said Secretary of Veterans Affairs Eric K. Shinseki. "This achievement demonstrates our dedication to being the provider of choice for Veterans."*

While all 152 VA medical centers are accredited by The Joint Commission, today's list recognizes medical centers that are top performers based on The Joint Commission's review of evidence-based care processes that are closely linked to positive patient outcomes. The 405 facilities on the list were identified for attaining and sustaining excellence in accountability measure performance for the full previous year (2010) and represent approximately 14 percent of The Joint Commission-accredited hospitals and critical access hospitals that report core measure performance data.

"VA health care has been a leader in performance measurement, electronic health records, research and clinical quality for more than a decade," said Dr. Robert A. Petzel, VA's under secretary for health. "I am proud of the staff and I fully expect to see more VA medical centers making this list next year."

**The list of VA Medical Centers on the Top Performers on Key Quality Measures for 2010 includes:**

- **Phoenix VA Health Care System; Phoenix, Ariz.**
- Nineteen Others Listed

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While the TJC awards are based on clinical outcomes, ultimately the results from thousands of assessment surveys and consulting engagements conducted during their monopoly should have uncovered the obvious, widespread failures in admissions and continuity of care. Over the last ten years, the VHA agreement with TJC would represent the 150 hospitals and 800+ clinics each being surveyed three times. The Survey process includes at least two important inputs that should have uncovered widespread mismanagement and multiple bookkeeping: The Tracer Process and the Public Comment period. The tracer takes random patient files and follows the continuity of care at each step in the process, from ER or admission to discharge and follow up. At Phoenix it could (should) have identified patients that were seen once or requested first-time appointments, but did not have any follow up activity in their records. The process is also supposed to solicit input from the Public through public comments prior to accreditation in every facility; to suggest there was no input seems unlikely given the thousands of vets who fell through the cracks. The big picture of what is needed at VHA is a balance of Access, Quality and Cost. Benefits touted on the TJC website, include:

- Provides a framework for organizational structure and management – Accreditation involves not only preparing for a survey, but maintaining a high level of quality and compliance with the latest standards. Joint Commission accreditation provides guidance to an organization's quality improvement efforts.

- Provides practical tools to strengthen or maintain performance excellence – The Leading Practice Library offers good practices submitted by accredited organizations. The Targeted Solutions Tool, an interactive web-based tool from the Joint Commission Center for Transforming Healthcare, allows accredited organizations to measure their organization's performance and help them find customized solutions for challenging health care problems.

## A Long History of Questionable Performance

Founded in 1951, TJC (previously JCAHO) is the largest external accreditation entity in Healthcare, enjoying a virtual monopoly in the industry for many years based on a Congressional mandate. According to their website, they currently accredit 20,500 facilities and programs. TJC also maintains a very large consulting organization, which is responsible to help clients prepare for and pass the Surveys. If it sounds like there may be a possibility of a conflict of interest, we can be comforted by a "firewall" that separates the consulting business from the survey business. The practice has had its' critics, who point out that many involved in the creation of standards and policy are also subject to that policy as TJC

customers. Growing to be the largest and most powerful accrediting entity did not come without some bureaucratic lethargy over time, and by the post-911 period, Government Accountability Organization (GAO) reports detailed large percentages of accredited hospitals that had serious deficiencies based on validation exercises:

"*In a sample of 500 JCAHO-accredited hospitals, state agency validation surveys conducted in fiscal years 2000 through 2002 identified 31 percent (157 hospitals) with serious deficiencies; of these, JCAHO did not identify 78 percent (123 hospitals) as having serious deficiencies. For the same validation survey sample, JCAHO also did not identify the majority (about 69 percent) of serious deficiencies found by state agencies. Importantly, the number of deficiencies found by validation surveys represents 2 percent of the 11,000 Medicare COPs surveyed by state agencies in the sample during this time period. At the same time, a single serious deficiency can limit a hospital's capability to provide adequate care and ensure patient safety and health. Inadequacies in nursing practices or deficiencies in a hospital's physical environment, which includes fire safety, are examples of serious deficiencies that could endanger multiple patients.*" – GAO-04-850 Medicare ***Patient Safety in Hospitals, July 2004 (One year prior to Hurricane Katrina)***

As All Hazards and Emergency Readiness consultants, our primary interest is with Safety and Security and Emergency Readiness in the Healthcare setting, which is the often the neglected side. We leave it to others to evaluate TJC's oversight of Clinical Safety and Security. Reports from Institute of Medicine, Consumer Reports and the Patient Safety Journal suggest that current clinical oversight from all sources has failed to meet public expectations.

## Who is responsible for oversight?

This answer to this question is complicated. There is a relationship between Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid (CMS) and the Veterans Administration (VA). The VA Secretary reports directly to the President and there are Congressional Committees in place to provide oversight. This is on the administrative side. The short answer is that the President is responsible with input from Congress.

On the Clinical side there are myriad State and Federal regulations that must be followed relating to worker health, drugs, safety and security, organ transplantation, etc.

As detailed above, to provide input on VA performance Congress has access to a few sources to inform their oversight:

a) Office of the Inspector General (OIG) reports. In short, the challenge with these is they are usually published two years after the research and all of the deficiencies are claimed to be fixed based on a system of inaccurate self-reporting.

b) Reporting from the VA itself should be a source of performance data, but this has been shown to be flawed through omission of information or commission of fraud.

c) Several external accreditation and certification organizations, the most important being the TJC, which enjoyed a long, congressionally-mandated monopoly that has been given to CMS. This monopoly seems to have transferred entirely over to the VA's approximately 150 hospitals and 850 outpatient clinics, despite TJC's documented underperformance, and CMS' move to increase competition.

Given the huge resources and effort required to maintain accreditation across all these facilities, TJC should be able to provide the best intelligence to Congress on what is actually going on inside every hospital in the organization; the primary input for Congressional oversight. This would be a foregone conclusion if they had found the fraud and broken processes at the Phoenix VA Medical Center, rather than declaring them one of the Top 20 in the country.

## How Can Oversight Be Improved in the Future?

Looking back on the three main sources of input for Congress to use for its' oversight responsibilities, we would recommend the following as a minimum approach to improve the system:

1. **Take advantage of the existing OIG reports**

    a) Use them in a defined process that actively looks at the recommendations
    b) Increase the number of validations using small samples to identify problems sooner and focus on high impact areas, with quick turnaround.
    c) Shake up the organization with Red Team Inspections; unannounced visits the day after new accreditation has been awarded – Do not rely on self-reporting
    d) Listen to the Customer – contact 100 new patient files and have them rate the satisfaction level of getting access, follow up care and discharge instructions.

2. **Reform the Management of the VHA for Increased Accountability**

    a) If the leader is military, they should have a deep background in providing healthcare, it is not a position that "checks the boxes" to get things done from top down, it requires an understanding of **service delivery** with leadership that can convince, not coerce people into doing the right thing.
    b) Leadership should review the processes for intake and follow up appointments and make sure it is balanced against available resources. If it is not reasonably possible to meet a target of 14 days for an appointment, then the target should change or the process should be fixed.
    c) Leadership should shake the organization out of its' complacency, anyone with fingerprints on the double filing system and their direct supervisor should be fired. Civil Service is not a meal ticket for life; the private sector has been decimated by market forces and there is no room for a nine-to-five attitude for those who want to keep their jobs and substantial benefits that have disappeared in the private sector. A personal example: after experiencing serious issues getting specialty care through a very unresponsive Nursing help line, I escalated to the Director of a VA Medical Center and sat with him, explaining in detail. In the conversation I suggested we call the help line or listen to the quality control recordings, stunned at the answer that **the union would not**

**allow recording of calls or calling with the purpose of doing an ad hoc assessment**. How can you manage quality of a call service without listening to the calls and holding people accountable for rude behavior or lack of follow up? The only way to manage a process is to measure it and improve based on valid data. Unfortunately, the vast majority of vets will not escalate the issues because they do not understand the bureaucracy and are afraid of angering their primary provider of care. In real life, if they don't escalate a follow-up appointment for a GI exam, they could end up with Stage 4 colon cancer and require a million dollars of care, and still not survive. The majority of staffers are individually very courteous and dedicated, but there is an overall culture that allows things to slip through the cracks that needs to be addressed. And fraud should have serious consequences.

2. These issues make VA a less desirable place to work for physicians and nurses, which in turn can impact the quality of care and the efforts to recruit talent into the system. Improvement of patient access, patient satisfaction and internal accountability will also improve job satisfaction and recruiting efforts.
3. It will be important to have a respected, hands-on operator in the leadership role, one who understands the limitations of the bureaucracy, how fraud and waste impact the quality of services, and the needs of patients when receiving quality healthcare. This should be a non-partisan issue. We feel that retiring Senator Tom Coburn of Oklahoma would be a good choice for the administration to tap for the open position, given the senator's background, training and willingness to cross the aisle for issues of importance.

4. **Introduce Better Quality and Accountability in External Evaluation Mechanisms**

a) The VA's exclusive external evaluation provider, TJC, missed the failures at Phoenix, actually awarding it a Top Performer accolade in 2010 and during the 2007 Walter Reed scandal mentioned above (that brought down the Secretary of the Army), Walter Reed Medical Center had been accredited with flying colors. While we understand that it is easier for VA to push everything related to accreditation (hospitals, labs, medical programs, pharmacy, etc.) to a single provider over a long period, a result that is typical in any business is that lack of competition and conflicts of interest result in lower quality deliverables to the end customer. Currently, VHA accreditation awards are written in a way that makes it almost impossible to be considered for those who do not offer every single requirement that is listed in the needs document. Communicating with VA on these awards is like speaking into a black hole; nothing ever comes out. Our company does not offer accreditation services but we do offer SME consulting on a subset of requirements in the areas of All Hazards Readiness. All Hazards Readiness has largely been underserved by the TJC standards over the years. **Opening up this accreditation monopoly to another firm or team of firms** to begin leveling the playing field, might be a little harder to manage for VA's compliance team, but we believe the benefits of increased competition, higher quality results and better transparency would be apparent.

b) The internal process of how the Accreditation Awards are validated should be documented and built into a process that ensures that adequate work is being done in this massive government contract, For example:
    1. Taking the Walter Reed Accreditation prior to the 2007 scandal and finding out how the substandard conditions at the facility were missed and how the Hospital received high marks in the accreditation.
    2. Looking at the latest Accreditation award for the Phoenix VA Medical Center and finding out how many tracers were performed and how the double set of books was missed.
    3. Understand using these two examples how the organization could be missing "the forest for the trees" in the current quality control and making appropriate changes internally at VA, and within the Accreditation Process to prevent this from happening in the future.
    4. Fully half of the Iraq and Afghanistan vets are coming home and claiming disabilities, we are just seeing the front-end of a lifetime of care for these vets, through the VA.
    5. This is a sixty year commitment that puts even more pressure on an already stressed system. Recent attempts to address the problems seem inadequate, i.e., allowing the patient to seek outside care after a certain waiting period, but having them manage their own continuity of care, and a very bureaucratic process that does not offer proactive care. If past is prologue, little will change.

**The 2014 Ebola Outbreak Represents a Massive Public Health Risk that is Being Ignored**

We have written several posts about the 2014 outbreak and have been alarmed at the lack of response by the International community to rally and intercept this growing threat. The current outbreak of Ebola in West Africa is growing at an exponential rate, i.e., on a track that continues to double the total caseload within half the time. Every day the international community waits without committing the hundreds of millions of dollars and massive deployment of infrastructure required to get in front of the epidemic means that hundreds more people die a most horrible and painful death. The United Nations cannot stop it, Doctors without Borders are completely overwhelmed, the individual countries do not have anything close to slow the disease in a single area - much less the country as a whole - and the US response has been far too little, too late. As detailed in the latest Foreign Affairs article titled "We could have Stopped This", Pulitzer Prize winning author and Senior Fellow for Public Health at the Council on Foreign Relations, Laurie Garrett wrote:

"This week CDC Director Tom Frieden returned from Liberia visibly stunned, flabbergasted by what he had witnessed, warning that "There is a window of opportunity to tamp this down, but that window is closing."" However, despite promising to commit more money and sending more people to region, the US is not prepared to support the effort without creating a much larger risk here at home. According to an **August 2014 OIG Report** titled *DHS Has Not Effectively Managed Pandemic Personal Protective Equipment and Antiviral Medical Countermeasures:*

**Key Findings:** 200,000 respirators in the National Stockpile have expired, along with 84% of the hand sanitizer. Of the 290,000 doses of influenza vaccine in stock, 81% will expire in 2015. Other findings

include the purchase of 16M surgical masks and 350,000 white coverall suits without demonstrating need.

Watching the **Frontline special** on the Outbreak, it is easy to see the absolutely primitive conditions the medical staff are battling, literally hacking out space in the jungle and erecting shelters without walls with corrugated tin roofs to segregate the patients and essentially wait for them to die.

With our military already stretched thin and assuming another round of fighting in the Middle East, we have made some commitments to use the military to build medical facilities. Unfortunately, as described in a Washington Post article today, we aren't really in a position to help even if we want to due to lack of expertise and available equipment. We are offering to put up a 25 bed hospital, with the geometrically progressing disease estimated to reach 20,000 victims in the space of a few more months.

In an eye opening move, the Gates Foundation pledged a record $50M, available immediately, to combat the rapid spread of the disease, exactly the kind of bold action required by governments to scale up the response to this crisis before it becomes a global pandemic event.

It may be difficult to get the attention needed to fix this problem with the global issues involving ISIL in Syria, Iraq and Kurdistan, the Ukraine and Estonia, however, each time the virus infects a human host, it has the opportunity of mutating to become more virulent or the true nightmare scenario: airborne.

Another frightening and plausible scenario **is** that **Boko Haram,** the brutal terrorist organization that has been terrorizing Nigeria for the last five years, could intentionally infect a "bio-martyr" who enters the US during the 21-day, asymptomatic incubation period and intentionally infects people in a major urban population center.

## CONCLUSIONS

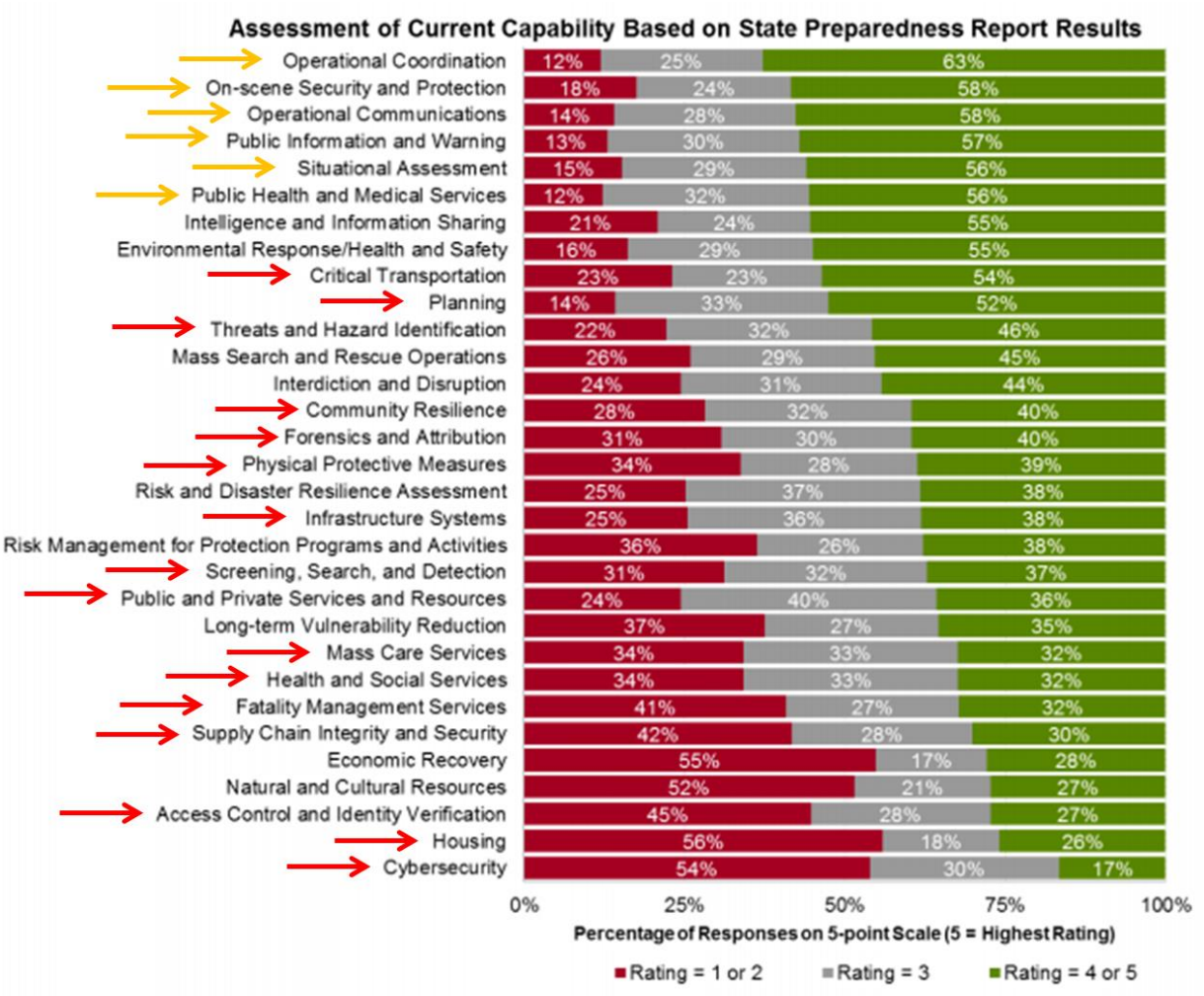
In Summary, during the period between 2009 and 2014, little has been done to increase the Safety and Security of the nation's Public and Private Healthcare Infrastructure, as demonstrated in the two major areas of concern: Clinical Safety and Physical Safety and Security in general, and Emergency Preparedness in particular.

In **Clinical practice**, estimates of the death toll from medical misadventure, such as physician error, hospital acquired infections and drug mishaps, remain in the hundreds of thousands per year, making this the third leading cause of death in the country, according to the **Journal of Patient Safety's 2013 Report**.

In **Emergency Preparedness** there has also been a lack of effective improvement over the last six years as demonstrated by the lack of readiness during many failures in Mitigation and Response in the face of more deadly natural disasters (Joplin, Irene, Sandy), more virulent and drug resistant bio-agents (SARS, MERS, EBOLA, MRSA, VRE) and continued growth in the rate of hospital violence from internal and external sources, such as active shooters and potential terrorist attacks.

**Overall National Readiness**

While we have covered many areas of readiness in this paper based on client (Healthcare-specific) All Hazards requirements and our own taxonomy, which uses the capabilities in scenario-based events such as hurricanes, earthquakes and pandemic outbreaks, the Federal Emergency Management Agency (FEMA) uses 31 capability areas in their annual readiness survey to respond to major All Hazards Events at the National level. Although almost every one of the 31 capabilities overlap with our All Hazards Assessment approach, our application is specific to Healthcare and can be used to ensure continuity of care at the hospital level, others are critical provide medical services at a community level. For example, Critical Transportation is required to move patients, but is also critical to resupply of medicine, consumables, food and water over the duration of the emergency. And Fatality Management Services are required both at the hospital level to ensure continuous operation and at the community level to prevent the spread of illness. Results of the national survey are seen in the chart and discussed below:



According to the 2014 **National Emergency Preparedness Report**, produced by FEMA, the industry For States and territories repeated the State Preparedness Report assessment process in 2013, rating their current capability levels relative to their preparedness targets for the 31 core capabilities. The assessment included a 5-point scale (with 5 as the highest rating) to evaluate each capability in terms of planning, organization, equipment, training, and exercises.

Results from the 2013 process were generally consistent with the previous year's results, with states and territories reporting incremental changes. Nationally, states and territories reported the strongest gains in Operational Coordination and Infrastructure Systems, while Supply Chain Integrity and Security experienced the greatest decrease. As in 2012, states and territories reported greater capability levels for common and Response core capabilities (see Figure 2) - 9 of the 10 highest-rated capabilities fell within those areas. States and territories rated themselves lowest in Cyber-security again in 2013, despite 82 percent identifying this core capability as a high priority. In post-assessment questions, participants reported making the most progress in the past year in Operational Coordination, Planning, and Intelligence and Information Sharing, whereas Cyber-security, Long-term Vulnerability Reduction, and Housing face the greatest danger of decline in capability.

It is important to keep in mind that self-reporting does not necessarily represent an accurate depiction of the level of readiness, it represents a self-assessment. We have found (as has CMS and other agencies) that self-reporting does not always reflect an objective and informed assessment. In many cases the documentation, training and level of knowledge among the general staff is far less complete than reported. Among the constants we see are that generally people underestimate the danger and overestimate their own capabilities to deal with a crisis event.

Among the National Economic Sectors within the Department of Homeland Security (DHS) critical infrastructure framework, Healthcare is a special case because of the high level of interdependence and need for Healthcare services. For example, if there is a chemical spill Healthcare will almost always be required, but other sectors such as postal and banking may not. Specifically for Public Health, the FEMA report brought out the following highlights:

- **Health and Social Services:** The Nation continues to promote expanded access to survivor medical records across jurisdictional boundaries, which supports disaster recovery. Use of electronic health records has increased significantly since 2008, with more than 50 percent of hospitals using them as of 2012. Despite this progress, systematic approaches for measuring community health following a disaster are still under development. Fewer states and territories identified this recovery-focused capability as an area of strength in the 2013 State Preparedness Report process, placing it in the bottom third of all capabilities.
- **Public Health and Medical Services:** states and territories identified Public Health and Medical Services as a high-rated core capability in exercises and testing. Meanwhile state and local public health agencies face continued budget uncertainties. DHS also identified biological concerns-including bioterrorism, pandemics, foreign animal diseases, and other agricultural concerns – as a top homeland security risk.

After several years of unsuccessfully encouraging and cajoling the industry to adopt post-9/11 voluntary compliance in Emergency Preparedness, the Centers for Medicare and Medicaid proposed new legislation in December 2013, through **CMS-3178-P**, which requires healthcare service providers to meet minimum standards of All Hazards Emergency Preparedness in order to qualify for Medicare and Medicaid payments, also known as Conditions of Participation (COP). All indications are that this new rule will be more aggressively enforced than existing accreditation mechanisms, just as the new CFATS legislation has been used in the chemical sector. Click **this link** for an in-depth view of CMS-3178-P, and what it means to hospitals and other healthcare service providers, and how CHCER can **help clients** meet the compliance requirements as quickly and cost-effectively as possible.