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

Backgrounder on the Non-Federal Healthcare Sector and Homeland Security Readiness

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. It is a fact that in a free, pluralistic healthcare industry, governance is a fragmented and complex undertaking. Preparing the nation's health delivery system to cope with nature's threats is formidable, adding the possible permutations of creative terrorist threats and newly emerging infectious diseases is mind numbing.

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, under Congressional mandates, Presidential Executive Directives and a plethora of Homeland Security Presidential Directives, has steadily moved toward national all-hazards readiness goals. Stimulated by the Oklahoma City Murrah Building bombing, 9/11 Terrorist Attacks and more recently the Katrina Gulf Coast Disaster the sector have evolved from WMD preparedness to an all-hazards strategy for Homeland Security.

The non-federal healthcare sector owns approximately *ninety* ***(90%) percent of the nation's healthcare delivery capacity***. This sector's professional leadership community

has shown little appetite to advocate for aggressive voluntary compliance within the 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. Many 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 built 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 for mitigating 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 is incalculable. The 21st-century healthcare

industry is in a building boom rivaled only by the Hill-Burton construction era.

Dual benefits associated with building in features that protect against bioterrorism have the secondary effect of dealing with current infection control challenges. Designing and constructing 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, an important aspect of safety and security for healthcare environments.

Hospital Boards and C-suite executives have failed to staff and fund their "Public safety and security functions". 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 settings and emergency departments, in particular, has become an unfortunate national trend. Shifting demographic and encroaching gang related violence has challenged the safety and security of previously secure neighborhoods. Women employees in healthcare organizations are among the nation's most victimized groups. 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 realistic 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 9/9/11 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 a 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, 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*" to *"attack".* 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 a 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 **P*atients*** who place their health/survival on their decisions, ***Staff/Employees*** depends 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 an intentional 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 were 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 has led to a misrepresentation in the level of facility safety and security. The "safety" in "quality and safety" has morphed into the exclusive domain of clinical practice.

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 realistically measuring preparedness progress for several reasons, 1.) Assessed indicators change each year 2.) Heavy reliance on self-reporting 3.) The practice of interest groups and an unwitting press taking information "out of context" from the report and spin it to promote misleading evidence of progress.

If the past is prologue, it teaches us that Americans are reluctant to enthusiastically prepare for known or perceived threats **even *in the face of existential threats***. This propensity for reactive behavior is legion. This cultural trait is found in many areas of the Healthcare Delivery Sector. It exists in the culture with few exceptions; the sector readily accepts advances in clinical technology and embraces its use, however, 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 Century's 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. 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. The HPH sector has many characteristics in common with the other seventeen. There is common agreement that without important elements of the nation's infrastructures, life as we know it would change dramatically. The HPH sector is unique among all the other sectors in that it **is *directly or indirectly*** involved in all hazardous events, be they naturally occurring or man-made.

The sector responds to thousands of events on a daily basis. Severe trauma and CBRNE accidents are daily occurrences. As ***"just in time"*** deliveries creates problems for the Transportation Sector, 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 illegal immigrant population creates challenges for many economic sectors. The HPH sector experiences direct and indirect economic impact, both known and unknown. The cascading effect of the spread of communicable diseases among this population is difficult to assess. Each time there is a loss of radioactive materials, 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 is not confined to increased internationally based terrorist plots characterized by last **year's** ***aborted seven planes London to U.S .terrorist plot.*** The recent conviction of the Lodi California's would be *"**Hospital and Super-Malls",*** Al Qaeda trained bomber, testified to a nation-wide plan to bomb hospitals and other "big buildings". 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"** to bring radioactive materials across domestic borders without detection is troublesome. Recent red teaming efforts resulted in defeating storage protection for a number of the 1200 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 an in-place dirty bomb. Repeated accounts of loss, theft and unexplained accounting for radioactive materials from Nuclear Plants and radioactive storage facilities add to the speculation that the ***availability of these materials*** to a terrorist is a reality. Documented accounts of relaxed security at research, diagnostic and

therapeutic sites are seen as terrorist bomb opportunity 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.***

Bioterrorism remains a major threat from both international terrorist and domestic extremists. Animal rights groups have aggressively attacked institutions using research animals. Earth Liberation and other environmental extremists groups have increased and pose serious threats to emerging nuclear and biological WMD counter measures. Management and Resources Information Sharing and Analysis Center (ERM-ISAC*) infograms* warn of the growing domestic extremist threats across the nation. United States 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 the **level of *threat and vulnerability***.

Lack of compliance with fundamental safety protocols has resulted in a number of self-inflicted events leading to millions of dollars in fines and research program suspensions. Personal Protective Equipment 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 from 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 terrorist, 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. Lessons learned from that tragic experience were known prior to Katrina/New Orleans from a million dollar exercise "PAM" and computer models using almost identical variables existing at the time of the Katrina event.

The Disaster Mitigation Act (2000) an amendment to the Stafford Act, required states to identify and mitigate known vulnerabilities or face a significant reduction in funding for losses which were deemed avoidable through proactive mitigation. States across the nation faithfully reported compliance by 1 November 2004.

Hospitals and other healthcare organization were ***Accredited or Certified*** **that they were in compliance with CMS, Conditions of Participation or its equivalence by proper oversight** authority, Armed with 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.

There are a number of pending publications which chronicle the day by day decisions of healthcare leaders prior to and through the first week of Katrina. ***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 the treatment of the eligible populations in the nation's federal healthcare programs. The 2007 revisions, to be enforced in 2008, were profound and for the first time in the 21st century hospitals were required to meet standards which would realistically position 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, Utility 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. This unprecedented Commission reversal of scoring standards which they had so skillfully articulated during the previous year does great harm to the 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 the active participation of U. K. **physicians as suicide bombers/homicide bombers (SB/HBs).** High ranking physicians have populated the terrorist ranks for decades planning a terrorist attack 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 percents 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 a 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 pulls up to an un-reinforced, unprotected glass lobby entrance, or a lone unchallenged mortuary vehicle backs up to the morgue with a casket filled with explosives or a IMG non-resident resident blows himself up in a busy hospital cafeteria, any or all of these known threats should have the effect of concentrating one' mind on the wisdom of a return on investment (ROI) for all-hazards readiness including infrastructure protection.

None of these actions is 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.

Reaction to Terrorist events is a highly individual emotion 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 the anywhere USA within the nation killing defenseless patients, caregivers, and others create 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 prepared 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 were 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, however, the planners had overestimated the sector's extant readiness posture.

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 ensure that "those who have borne the battle" receive the same level of care and the 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 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.

Filename:	2008 Non Federal Healthcare and Homeland Security Readiness White Paper.docx
Directory:	C:\Users\staples0560\Documents
Template:	C:\Users\staples0560\AppData\Roaming\Microsoft\Templates\Normal.dotm
Title:	
Subject:	
Author:	James D. Blair
Keywords:	
Comments:	
Creation Date:	10/7/2016 2:13:00 PM
Change Number:	2
Last Saved On:	10/7/2016 2:13:00 PM
Last Saved By:	staples0560
Total Editing Time:	1 Minute
Last Printed On:	10/7/2016 2:14:00 PM
As of Last Complete Printing	
Number of Pages:	15
Number of Words:	5,253 (approx.)
Number of Characters:	29,948 (approx.)