Comments Docket ID FEMA-2008-0017, 14 Jan 2010

PRIVATE SECTOR PREPAREDNESS

PUBLIC HEALTH AND HEALTHCARE SECTOR

The development of standards within a new Voluntary Private Sector Preparedness Program for the Healthcare Industry should not be modeled on the extant Hospital and Healthcare external evaluation mechanisms.

The nation's non-federal healthcare sector has resisted any meaningful voluntary all-hazards safety and security preparedness in the post- cold war era. Presidential Executive Orders and a plethora of Homeland Security Presidential Directives have done little to move the sector toward partnership in the national strategy for homeland protection.

Touted as one of the most regulated industries in the country it also owns the title of the "weakest link in the Homeland Security chain". Extant external oversight mechanisms have ignored the built-in vulnerabilities of new design and construction of healthcare facilities. The 2006 (added 2010) edition of the AIA guidance for design and construction for healthcare facilities is an example of an entire sector in denial. This document is updated every four years and is reviewed and endorsed by established experts in all sectors, private, public, governmental and academia. It appeared that the document had escaped any review at the Department of Homeland Security.

The opportunity lost over the last decade to design and construct healthcare facilities which mitigate known hazards is incalculable. The duel benefits of building more robust facilities which protect against known threats from terrorism also protect against natures disasters.

The national shift away from bioterrorism to pandemic protection has resulted in a lack of protection for either. The nation was ill prepared for the 2nd wave of H1N1 with reports that hospitals had not developed emergency planning for a known pandemic. It should be noted that these facilities had been awarded, at some level of government, accreditation/certification and many had met the requirements of

"deemed status" making them eligible for federal reimbursement for the treatment they provide.

The industry is hard pressed to deal with "healthcare acquired infections". Post "IOM to err is human" hospitals, a decade later, are some of the most dangerous places in the world. It takes little imagination to speculate on the impact a bio-agent, by intent or accident, introduced into such a vulnerable environment. The proliferation of Bio-Labs across the nation has greatly increased the probability of this type of event. Bioterrorism counter-measures may have produced more threats than solutions. Documented reports of poor safety and security practices and rapid increases in employees with access to some of the world's most dangerous bio-agents and toxins increase concerns for insider threats.

The industry is faced with serious shortages in many classes of caregivers. The demand has outstripped the available home grown supply of caregivers and the industry has looked to other countries to fill the gaps. Unfortunately, at a time when background checks should be a priority, they are not. There is a prevailing attitude that to question those who would most likely be an insider threat is "politically incorrect". Aside from the obvious implications that this has for all-hazards readiness, it has resulted in a dangerous workplace environment for employees in general and female caregivers in particular. Female caregivers are the most frequently assaulted workers in the nation's workforce. This population is also under constant threat from outside threats as well. Underfunded Safety and Security functions are a norm in the industry, making it difficult to protect stakeholders under normal operational circumstances and impossible during all-hazards events. Facility/physical safety and security (a cost center) has been sadly neglected and Hospital Safety and Security has morphed into an exclusive clinical domain.

Healthcare organizations have developed elaborate mass casualty and surge protocols. These protocols depend on *"freedom of movement by caregivers and control of crowds"* to be successfully executed. Safety and security of limited treatment stockpiles are as secure as staff ability to protect them. The "return on investment "for a well-trained and numerically sufficient security force" has failed to capture the imagination of C-suite dwellers.

Few decision makers have realized or fail to acknowledge the post 9/11 events which place Hospitals as soft and desirable targets. Weeks following the 9/11 attacks were followed by low profile alerts to clustered Healthcare Centers in the nation's largest and most populated cities. Later Veterans Hospitals were alerted that terrorists viewed them as military targets. Serial successful attempts by intruders with false IDs and elaborate, but, believable stories entered hospitals without resistance. The only common element was that they were hospitals.

The issue of hospitals as "soft targets" is not novel, it happens too frequently around the world. The decision makers within the Homeland Security Community have not given the issue a profile which it deserves. Mumbai is a recent example where little attention was given to the CAMA hospital attack.
The trusting public has been poorly protected by an industry which places its most vulnerable charges at risk in the face of mounting evidence that the triple threats of: evolving infectious diseases; more frequent and robust natural disasters and increasing evidence that hospitals are "Soft and Desirable Targets". Over 900 hospitals and healthcare facilities have failed to harden what the Defense Science Board call "low-hanging fruit" ½ of the dreaded "dirty "bomb, Cesium 137 containers.

We urge the DHS-PS-PREP committee to take an in-depth look at the current status of volunteer compliance to basic DHS initiatives, NRF, NIPP, NIMS etc.

We posit that the desired readiness posture in the non-federal healthcare sector is critically ill. It is worth the time and effort to create standards for readiness which meet the needs and expectations of a trusting public.

Formal and informal "red teaming" of healthcare facilities provides evidenced – based security weakness in all areas of hospitals.

These outside and insider threats will only increase as the expected healthcare reforms will stress an already stressed system.

Since these new certifications will be voluntary in nature it would make sense to make them real.

Post Script-

The tragic neglect of pre-Katrina /New Orleans healthcare community has re-surfaced in the form of litigation stemming from the deaths and injuries of the most vulnerable among us, defenseless frail hospitalized patients.

DHS and FEMA should take notice that over a hundred of these victims perished in Hospitals which had Accreditation from until recently, by an organization which had a virtual Congressional monopoly on hospital external evaluations.

Legal scholars posit that this may not only be a wake-up call for these organizations but also for oversight bodies at all levels of governance.

Thank you for the opportunity to share our concerns. Jim Blair