From: Dr. James Blair
To [redacted]
Sent: Sunday, June 24, 2007 10:20 PM
Subject: Request a dialogue AIA's Healthcare Design and Construction Guidance for Hospitals and Healthcare Facilities.

Sir, over the years we have expressed our increasing concerns relative to the non-federal healthcare sector's failure to meet its expected role and responsibilities in the evolving strategy for Homeland Security preparedness. This sector controls ninety (90%) percent of the nation's healthcare delivery resources. The effectiveness of the National Strategy for Homeland Security Protection depends on a mix of mandated and voluntary partnerships composed of the nation's economic sectors. The protection is designed around a united framework of interdependent partnering in this long and, for the most part, unpredictable struggle with looming existential threats:

Emerging infectious diseases (Pandemics);

More robust Natural disasters (Katrina, Ice storms etc.);

Increasing evidence that hospitals in general and clustered Urban Medical Centers, in particular, are seen as "soft" primary or secondary targets for terrorist attacks. The "terror multiplier effect" (TME) of killing large numbers of caregivers and simultaneous denial of care for other casualties is a tempting idea. We cannot dismiss the message we get from recent hospital "midnight visits" by unknown imposters, not only gaining access to facilities but given sensitive information. These events do not have any common thread relative to Healthcare ownership, specialty, geographic location, or size.

Our emphasis is on the third threat because your industry is in the midst of a "Building Boom" essentially replacing a generation of Healthcare Workplaces. We find that the federal sector and many public sector structures are built to standards which protect them against known future threats and designed and built using " Lessons Learned/ Best Practices" to reduce dangers in a known hostile environment. The unthinkable "irony" is that it is far safer to send folks to a Federal Post Office, Museum, or Federal Court House than to a non-federal healthcare treatment establishment.

Post Katrina, we evolved from a central focus on CBRNE readiness to All-Hazards readiness. We find that the "Green Guide" frenzy, as politically and psychologically comforting as it is, brings with it a potential for some disturbing unintended consequences. In much the same way as, the "safety" in IHI "quality and safety' has morphed over the years into an exclusive clinical domain, Green has come to mean all that is good and desirable in design and construction. Example, healthcare professional publications closely followed by the popular press (Time, Newsweek etc.) have listed "the 100 Best and Safest Hospitals", HealthGrades helps you choose Quality Caregivers in your area). The quality, safety, and other advantages in leading edge technology were evaluated without consideration of Physical Security, Structural Integrity or, near-term, all-hazards threats. The excitement over equitable access, quality care, at a reasonable price can be neutralized by the actions of one missed suicide bomber or a ten minute release of deadly biological agent into an unprotected air intake system.

An unavoidable aspect of age related chronic healthcare challenges is that one visits a mix of healthcare facilities for diagnosis and treatment and the more novel the condition the greater the opportunity to travel about to geographically diverse regions for care. The ease with which patients, staff, vendors and would-be terrorist have access to all areas of these facilities is frightening. Great unprotected glass atria found at most urban hospital entrances are devoid of even tastefully decorated physical barriers. The creative minds of those dedicated to end our way of life, unfortunately do not have to work overtime to identify vulnerability within the Nation's non-federal healthcare community. The potential for death and destruction created by the explosion of a VIP limo laden with a thousand pounds of conventional explosives is horrible and is a known terrorist tactic. Stolen or purchased used ambulances and the lonely mortuary transports pose a similar threat.

The first part of this communication is essentially a Prologue to a discussion with AIA leadership. What you find below is, what I take to be, an AIA Segment's response to our assessment of last year's publication of the 2006 Guidance for Design and Construction of Hospitals and Healthcare Facilities.

We realize that this Guidance, often called the "Bible for the Healthcare Building Industry" has been reviewed by an august group of "interested parties" recognized experts in their respective professions.

Our shock and awe reaction to the 2006 publication was centered on its failure to address existing all-hazards threats. Recent news accounts reveal that resident Muslim males within certain age groups would resort to suicide bombing to defend their religious beliefs. We take little comfort in the prospect of a 2010 edition to guide us through proactive considerations for methods to protect a vulnerable and trusting healthcare public. The Hospital industry and those associated support entities (enablers), failed or failing oversight mechanisms, can ill afford another systems failure as experienced in New Orleans. JB

Dear Dr. Blair:
I have read your email with great interest and would like to make the following comments and observations. Before I comment on your impression of the Guidelines revision process and the minimal effort in writing requirements to protect against terrorist efforts, I would like to state that all 125 committee members are dedicated to making the Guidelines for the Design and Construction of Health Care Facilities a "top-notch" set of recommended standards for all types of health care modalities. There is not a person on the committee that has intentionally tried to keep any efforts to add language for "hardening" our health care buildings out of the Guidelines.

The 2006 edition of the Guidelines was published and released to the public in July of 2006. It has already been adopted by more than 6 states with many more making provisions for updating to the 2006 from older editions of the document. This document can be purchased from the AIA or the American Society for Healthcare Engineering.

DHHS participated on the Steering Committee of the 2006 Guidelines with representation from CMS (2 people), NIH, and HRSA. Many of these DHHS members have a longstanding history with the Guidelines and have served in a leadership capacity for decades. We also have representation from NIOSH, two from CDC, and have added [redacted] to the 2010 revision committee.

The 2010 Guidelines cycle is currently open for public comment. I am attaching the press release about the process and how to participate by recommending new text for consideration by the HGRC. While the document and process is not ANSI approved, we do follow their rules for producing consensus documents. We are hopeful that you and others with expertise in the business of designing "hardened" health care facilities will submit proposals for the 2010 document.

While we are trying to limit the size of the revision committee to 125, if you feel that [redacted] would be a good addition to the committee I recommend your forwarding their name and resume to me for consideration. It was unfortunate that [redacted] missed our kickoff meeting this April as that would have been a perfect opportunity for us to begin this discussion with the entire revision

committee.

I hope this has provided an insight to the process and also answered some of your questions on the 2006 document.