Hospital Security News

SAI provides professional expertise to assist hospitals in developing an effective security and risk management program.

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"Hospital Security News" is SAI's quarterly newsletter dedicated to helping hospitals identify and manage their security risks, recognize organizational strengths and weaknesses in physical protection and improve the personal security of patients, staff and individuals that use their facilities. This special edition features an article on hospital bioterrorism preparedness written by SAI for Larry Anderson, Editor of 'Access Control & Security Systems' magazine.

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"Bioterrorism: Are Hospitals Our Weakest Link?"

Hospitals play an essential role in community preparedness for terrorism and other hazards, both natural and manmade. Even prior to 9-11 hospitals were judged to be a weak link in community disaster preparedness, especially for incidents involving patients contaminated with nuclear, chemical or biological agents. Terrorism preparedness efforts of the past two years have identified significant obstacles that have made hospitals reluctant to partner with communities thus creating ineffective response. With the expenditure of considerable federal resources to develop and test community-wide mass casualty response plans, many of these obstacles are being addressed. The hospital's link in terrorism preparedness chain is getting stronger, but many obstacles remain.

Hospitals have developed and exercised Emergency Preparedness Plans (also called "disaster plans") for as far back as anyone can remember. Early plans covered a range of natural and manmade disasters, but did not include preparation for mass casualties due to terrorism. In the mid-1990's hospital preparedness plans followed the broad, national requirements imposed by FEMA, HHS, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) with more than 100 other government agencies sharing various levels of preparedness responsibility. Hospitals were given a broad preparedness mandate summarized by this general statement of expectations:

> *"The hospital must have an emergency preparedness system for managing the consequences of power failures, natural disasters or other emergencies that disrupt the hospital's ability to provide care."*

JCAHO requirements applied specifically to accredited hospitals ranging in size from small rural facilities to large urban medical centers. JCAHO pre-9/11 preparedness standards focused on four areas:

- Emergency preparedness management plan
- Security management plan
- Hazardous materials and waste management plan
- Emergency preparedness drills

Hospital disaster planning, included planning for nuclear accidents and incidents, has been on going for decades at all levels of government. This planning was done without provision for mass casualties due to acts of chemical or biological terrorism. But even before 9/11 this was beginning to change.

In January 2001, the Joint Commission revised their existing standard to require an "all-hazards" approach to disaster preparedness that embodied the four traditional phases of emergency management (mitigation, preparedness, response and recovery). Acts of chemical and biological terrorism certainly qualified for preparedness planning under the new "all-hazards" approach. However, only a small percentage of the nation's 6,000 hospitals had worked to achieve a reasonable state of readiness prior to 9/11. The reason is understandable. Acts of terrorism in the U.S. were extremely rare. When hospitals began using the hazard vulnerability analysis (HVA), part of the new JACHO standard, to identify and rank the most likely and most catastrophic incidents they faced, terrorist acts were typically not even considered. When considered in the HVA, chemical and biological terrorism ranked at or near the bottom among the range of potential hazards facing hospitals.

Immediately after 9/11 hospitals scrambled to include terrorism in their vulnerability analysis. They contacted community organizations, public health departments, and emergency services to help them incorporate a terrorism element into their "Emergency Management Plan". Tabletop drills and planning for full-scale, community-wide mass casualty exercises began in earnest.

Federal, State and local governments mobilized to fight terrorism on all fronts. The "Office of Homeland Security" was established within White House to provide a unified homeland security structure. Legislation to create the Department of Homeland Security (DHS) was singed into law on November 25, 2002, and by March 1, 2003 the department was "up and running." Agencies that were responsible for hospital preparedness were consolidated and moved under the DHS. The agencies moved under DHS include: FEMA (Federal Emergency Management Agency), HHS Office of Emergency Response (OER) - previously named Office of Emergency Preparedness, National Disaster Medical System (NDMS), Metropolitan Medical Response System (NDMS), Centers for Disease Control (CDC) and the Strategic National Stockpile (formerly named National Pharmaceutical Stockpile), being among those most familiar to healthcare professionals. Health and Human Services (HSS) retained as the lead agency to coordinate *health assets* under the Federal Response Plan Emergency Support Function.

In February of 2002 the American Hospital Association (AHA) sent surveys to approximately 5000 hospitals asking them to assess their readiness to handle a terrorist attack. Out of the 1,700 hospitals that responded; 69% had already incorporated a bioterrorism response into their disaster plans, 28% expected to do so within the next 12 months, 77% had established a terrorism component and 20% anticipated adding a terrorism component within the year. Over three quarters (78%) indicated that financial resources limited their ability to establish additional safeguards.

Government responded. By June 2002 – HRSA (*Health Resource and Services Administration)*, a branch of the Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) had issued grants totaling $182 million to the 50 states and several cities. The goal of this grant funding was to achieve "17 critical benchmarks for bioterrorism preparedness planning." Fourteen benchmarks were overseen by the CDC and related to public health preparedness. The three benchmarks under HRSA purview related to hospital preparedness.

1. Designate a Coordinator for Bioterrorism Hospital Preparedness Planning.
2. Establish a Hospital Preparedness Planning Committee to provide guidance, direction and oversight to the State health department in planning for bioterrorism response.
3. Devise a plan for a potential epidemic in each state or region. Recognizing that many of these patients may come from rural areas served by centers in metropolitan areas, planning must include the surrounding counties likely to impact the resources of these cities.

In total, the DHS and HHS spent $3.01 billion in FY 2002 to fund all of the various components for bioterrorism terrorism preparedness nationwide. This was a 10-fold increase over $305 million spent in FY 2001. Total bioterrorism funding was $4.4 billion in FY 2003, and FY 2004 is projected to be $5.2 billion. (See: Graph #1)

As related to hospital preparedness, these expenditures have been used to:

- upgrade infectious disease surveillance and investigation
- enhance the readiness of hospitals and the health care system to deal with large numbers of casualties
- expand public health laboratory and communications capacities
- improve connectivity between hospitals, and city, local and state health departments to enhance disease reporting
- strengthening public health preparedness to address bioterrorism, outbreaks of infectious diseases and public health emergencies
- conduct readiness assessment
- dissemination health information, provide education and training, and smallpox preparedness planning
- develop surge capacity to deal with mass casualty events, including the expansion of hospital beds, development of isolation capacity, identifying additional health care personnel, establishing hospital-based pharmaceutical caches, and providing mental health services, trauma and burn care, communications and personal protective equipment

Have these funds been used effectively? In the middle of 2002 a General Accounting Office survey of more than 2,000 urban hospitals found that four out of five of the hospitals surveyed had a written emergency response plan that addressed bioterrorism, but most plans omitted key information such as contact number for local laboratories. Also evident was the lack of regional and statewide coordination in major disaster drills and exercises. Fewer than 50% of the hospitals surveyed had conducted drills or exercises simulating a response to a bioterrorism incident. The majority of hospitals surveyed from May to September 2002, revealed that they also lacked medical equipment that would be essential for an influx of mass casualties. Oral comments by representatives of the American Hospital Association (AHA) show they generally agreed with the GAO findings.

Several notable exceptions to the general lack of county-wide terrorism exercises took place in 2002 with large-scale simulations taking place in North Carolina, Texas and Florida. High Point Regional Health System, for example, successfully completed the first community-wide exercise in North Carolina in April, 2002. They participated with two other regional hospitals and forty two Federal, State, county, and municipal agencies in a simulated chemical terrorism attack during a large sporting event. Their goal was to:

- Participate in a Community-wide Disaster Drill
- Receive and Track Mass Casualties
- Decontaminate and process victims
- Provide Personal Protective Equipment
- Provide facility and staff with Safety & Security
- Provide equipment and training for hospital & staff

Post exercise findings and follow up were extremely helpful in identifying strengths and weaknesses in High Point’s major disaster plan.

Even today, as vital as these exercises are to effective preparation, a large percentage of hospitals are still only in the planning stage. They have yet to participate in a community-wide or regional major disaster exercises. Recently completed disaster exercises as well as the actual responses to disaster events across the U.S. have exposed some common recurring areas where obstacles arise. Until overcome, these obstacles will continue to hinder efforts to create and implement more effective responses to mass casualties.

Recurring problem areas are:

- Communications
- Hospital security
- Decontamination procedures, equipment, and training
- Exercise realism, content and follow-up
- Lack of specific benchmarks for hospitals to use in planning
- Specific directives from State Hospital Bioterrorism Preparedness Planners

Systemic obstacles within the healthcare industry itself also limit a hospital's ability to prepare effectively in some of the critical ways necessary to fully meet terrorism threats.

Systemic obstacles that affect the majority of hospitals:

- Enormous downsizing as a result of "Managed Care"
- Competitive pressures to cut cost
- Just-in-time pharmaceutical supplies and staffing practices
- Limited capacity of certain specialty services
- Approximately 30% of U.S. hospitals are operating at a financial loss
- Staffing shortages across a wide range of skill levels and specialties
- High staff turnover rates

By definition, mass casualty incidents will overwhelm the resources of individual hospitals. The ability to mount an effective response will depend on the nature and magnitude of the event. Multiple events that may also disrupt communications and utility services or require evacuation of hospital facilities must also be considered. To be effective any response will require a high level of coordination among first responders and emergency personnel. Depending upon circumstances, a coordinated local response may be sufficient for community recovery. In worst case scenarios, the coordinated response would be statewide, regional or even national.

From an individual hospital's perspective the staff and equipment required to respond effectively to a terrorist attack generating mass casualties are far greater than what are needed for everyday performance. Equally important, a mass casualty incident is likely to impose a high sustained demand on health services rather than the customary short, intense peak associated with smaller scale disasters. Hospital staff themselves must also be protected from chemical or biological agent(s). This adds another dimension of complexity for hospital preparedness planners.

Terrorism preparedness is expensive and hospitals are reluctant to create capacity that is not needed on a routine basis and may never be used. In addition, along with a hospital's ability to meet the routine needs of the community, the need for additional capacity to respond to bioterrorism emergencies must be balanced with the need to be prepared for all types of emergencies. Terrorism events still earn a low priority rank in most hospital vulnerability assessments (HVA). None-the-less, hospital officials recognize that their facilities are an essential component of our nation's terrorism preparedness, and they are planning and training to increase their response capacity.

Most hospitals, however, still lack equipment, medical stockpiles, and quarantine and isolation facilities for even a small-scale response. Respirator isolation beds and burn units could very easily become critical should a biological /chemical terrorist attack occur. Not only is availability of equipment a problem, hospitals have to take into consideration the potential cost that would be incurred, as well as the need for preparatory investments, which may not be reimbursed after a crisis is over.

None-the-less, hospitals are expected to have an adequate supply of personal protective equipment (PPE) and clothing on-hand that includes:

- Gloves, gowns, HEPA masks (OSHA/NIOSH – approved high efficiency particulate
- Goggles, shoe covers (available in all sizes), enough inventory for frequent changes.
- Fit-Testing for all employees
- Level B protection (for front-line employees and custodial staff
- Self-contained breathing apparatus w/ positive mode
- Hooded, 2-piece chemical resistant suits
- Chemical resistant gloves and boots

Healthcare facilities must also comply with myriad government regulations related to patient safety standards promulgated by OSHA and the EPA as well as track and follow mandates, guidelines and directives from the FDA, CDC, HIPPA and others. Accredited hospitals must also demonstrate adherence to a diverse set of non-governmental standards during periodic surveys by the Joint Commission.

Hospitals are also required to provide regular "in-service" training programs and readiness drills for their terrorism preparedness plan. All these practices are expensive and hospitals can end up losing money preparing for an event that may or may not occur. Cash-strapped hospitals faced with the choice between purchasing a piece of much needed medical equipment, or having to buy bioterrorism preparedness equipment for an event that may never happen, are faced with a difficult dilemma.

Summary:

Many obstacles and challenges facing American's hospitals have been identified as preparation continues for possible catastrophic acts of terrorism. Solutions to overcome them are being studied, tested and implemented at an increasing rate. States have completed the 3 critical benchmarks for hospital bioterrorism preparedness mandated by HRSA in their hospital preparedness grant program. Texas and several other states have completed Hospital Bioterrorism Preparedness Plans. These plans offer specific directives for state health departments to share with hospital planners in the design and implementation of their preparedness plans and exercises.

Total government terrorism preparedness funding continues to increase. Funds for hospital preparedness are being directed towards overcoming the obstacles of communications, security, decontamination procedures, equipment, and training and realistic exercises with follow-up. U.S. hospitals are by no means totally prepared for a terrorist incident where chemical or biological agents cause a massive number of casualties. By definition they can never be 100% prepared. However, hospitals are now better prepared and far more capable of mounting an effective response to terrorism than ever before.

HSS Secretary Tommy Thompson stated the following on January 29, 2004 during remarks to the press on the DHS Bio-Surveillance Program Initiative.

"The contrasts between what we were doing a few years ago and what we're doing today is absolutely striking. The amount that HHS spends on bioterrorism preparedness is absolutely 12 times as much as three years ago. We've gone from $300 million in 2001 to $3.9 billion, which was requested for this year. And I'm happy to say that we are better prepared to prevent and respond to any public health emergency in America."

Bibliography:

"*17 Critical Benchmarks for Bioterrorism Preparedness Planning*," Department of Health and Human Services press release, June 6, 2002

Hospital Preparedness: Most Urban Hospitals Have Emergency Plans but Lack Certain Capacities for Bioterrorism, General Accounting Office Report 03-924, August, 2003

"*Hospital Preparedness for Mass Casualties: Summary of an Invitation Forum*," final report, August, 2000; Invitational forum convened 8-9 March, 2000 by the American Hospital Association, with support from OEP and HSS

NBC Terrorism Preparedness Conference – *How Well is Your Hospital Prepared for Terrorism & Mass Emergencies*? Audio Conference hosted by Security Assessments International, Inc., January 22, 2002

Audio Conference Documents supplied by High Point Regional Hospital included:

- Emergency Preparedness Management
- Hazard Vulnerability Assessment
- Hazard Vulnerability Analysis
- Major Disaster Plan
- Incident Command Team & Incident Command Center
- Terrorism Response Plan - NBC Preparedness Response Plan - response to Nuclear, Chemical and Biological terrorism

Fact Sheet: "*Public Health Emergency Preparedness – Transforming America's Capacity to Respond*" - September 11,2003, HHS Press Sheet

Recurring Pitfalls in Hospital Preparedness and Response, by Jeffrey N. Rubin, Homeland Security Journal, January, 2004

Bio-Surveillance Program Initiative Remarks, DHS/HSS Joint Press Conference, January 29, 2004

On-line resources

Bioterrorism Preparedness and Response
http://www.healthpolicyinstitute.org/projects/disaster_response/guidance_document.pdf

HRSA Hospital Bioterrorism Preparedness
http://www.hrsa.gov/bioterrorism/preparationandplanning/healthcare_hospitals.htm

Hospital Preparedness Program Documents
Security Assessments International

Future Newsletter Topics

Hospital Liability "When to hire a Security Expert"
Components of a "Self-Assessment"
Educating Employees and Staff
How to select an infant security system
State-of-the-art protection for Emergency Departments
Violence in the workplace
Access control / lockdown
Parking deck and parking lot lighting

Note from SAI: Twenty plus years of experience as hospital security professionals has taught us that each facility is unique. Many factors have to be taken into consideration when assessing the vulnerability of a particular hospital. This can only be accomplished through an on-site visit. The preceding article written by Jeff Aldridge appeared in Access Control & Security Systems Integration magazine.

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