

...ING TECHNOLOGY TO PROTECT PEOPLE, FACILITIES AND ASSETS

ACCESS CONTROL & SECURITY SYSTEMS

securitysolutions.com

AUGUST 2004

**Demonstrating
SYSTEM CAPABILITIES**
A List Of Questions To Ask Before Signing Off

**Dealing With
WORKPLACE VIOLENCE**
Training Is Key Component For Medical Community

**Standards For
PHYSICAL & IT SECURITY**
Collaboration Fills In The Gaps And Drives Convergence

**ARE
HOSPITALS
OUR
WEAKEST LINK?**

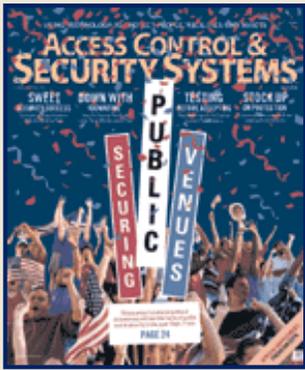
When dealing with bioterrorism, hospitals are starting to rise to the challenges of Homeland security, yet obstacles remain

PAGE 20

**ADVISORY COLORS
& CORPORATE SECURITY**
From Green to Red:
A Step-By-Step Plan
Of What To Do **34**

A PRIMEDIA Publication

ACCESS CONTROL & SECURITY SYSTEMS



[SUBSCRIBE HERE](#)

Click here
to
subscribe

SECURITY
BEAT

- [Home](#)
- [Subscribe](#)
- [Buyers' Guide](#)
- [Sourcebook](#)
- [Industry Calendar 2005](#)
- [Editorial Submission Guidelines](#)
- [Product Info](#)
- [Newsletter](#)
- [Industry Associations](#)
- [Research](#)
- [First Monday](#)
- [2004 Product of the Year Contest](#)
- [Marketing Info](#)
- [Rent Mail Lists](#)
- [Rent E-mail Lists](#)

ARE HOSPITALS OUR WEAKEST LINK?

Aug 1, 2004 12:00 PM

By JEFF ALDRIDGE & PHILLIP LAUNT

Hospitals play an essential role in community preparedness for terrorism, but even prior to the Sept. 11 attacks, 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 have led to considerable federal efforts to develop and test community-wide mass casualty response plans. The hospital's link in the terrorism preparedness chain is getting stronger, but obstacles remain.

FROM EMERGENCIES TO TERRORISM

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 man-made disasters, but did not include preparation for mass casualties due to terrorism. In the mid-1990s hospital preparedness plans followed broad, national requirements imposed by the Federal Emergency Management Agency (FEMA) and the Department of Health and Human Services (HHS), with more than 100 other government and quasi-government agencies sharing various levels of preparedness responsibility.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a not-for-profit organization, is the nation's predominant standards-setting and accrediting body in healthcare. The Joint Commission's pre-Sept. 11 preparedness standards applied specifically to accredited hospitals ranging in size from small rural facilities to large urban medical centers and were focused on emergency preparedness management plans, security management plans, hazardous materials and waste management plans, and emergency preparedness drills.

Hospital disaster planning, including planning for nuclear incidents, had been ongoing for decades at all levels of government, albeit without provision for handling mass casualties due to acts of chemical, biological or nuclear terrorism. This situation was changing long before Sept. 11. In 1999, the HHS budget included a modest level of funding for a public health response to "any instances of bioterrorism." HHS funding and preparedness for bioterrorism was increased in FY 2000 and again in FY 2001.

In 2001, the Joint Commission revised its existing standards to require an "all-hazards" approach to disaster preparedness. The revised standard embodied the four traditional phases of emergency management (mitigation, preparedness, response and recovery); meaning that acts of chemical and biological terrorism 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 by Sept. 11, 2001. When hospitals began using the hazard

[EMAIL THIS ARTICLE](#)

DSX Access Systems, Inc.
ACCESS SYSTEMS, INC.
 Quality, Reliability, Integrity.
 The Security Professionals' First Choice.
 888.419.8353
 www.dsxinc.com

THE LATEST

- [First Monday](#)
- [2004 Product of the Year Contest](#)

**2004 Online
Directory**

**ACCESS CONTROL &
SECURITY SYSTEMS**

GOVERNMENT SECURITY

**Your Ultimate
Online Resource
for Security
Technology.**



▫ [Digital Ads](#)

▫ [About Us](#)

▫ [Contact Us](#)

**GOVERNMENT
SECURITY**

vulnerability analysis (HVA), part of the new JACHO standard, to identify and rank the most likely and catastrophic incidents they faced, terrorist acts were typically not considered. Even when considered in the HVA, nuclear, chemical and biological terrorism ranked at or near the bottom among the range of potential hazards facing hospitals.

During the turbulent months following the 2001 attacks, four letters containing anthrax spores were mailed to media personnel and two U.S. Senators. Twenty-three people contracted anthrax and five died from the exposure. Hospitals, in turn, scrambled to include bioterrorism in hazard vulnerability analyses. Planning for full-scale, community-wide mass casualty exercises began in earnest.

Eventually, agencies responsible for hospital preparedness were consolidated and became part of the Department of Homeland Security, including FEMA, the HHS Office of Emergency Response (OER), National Disaster Medical System (NDMS), Metropolitan Medical Response System (MMRS), and the Strategic National Stockpile.

MEASURING READINESS

In 2002, the American Hospital Association (AHA) surveyed approximately 5,000 hospitals, asking them to assess their readiness to handle a terrorist attack. Of the 1,700 hospitals that responded, 69 percent had already incorporated a bioterrorism response into disaster plans, 28 percent expected to do so within the next 12 months, 77 percent had established a terrorism component and 20 percent anticipated adding a terrorism component within the year. The majority (78 percent) indicated financial resources limited the ability to establish additional safeguards.

The government responded by issuing grants totaling \$205 million to the 50 states, several territories and major cities. This was followed up mid-year with the release of an additional \$747 million. The goal of this grant funding was to achieve “17 critical benchmarks for bioterrorism preparedness planning.” Fourteen benchmarks were related to public health preparedness, while the remaining three were related to hospital preparedness. Hospitals were directed to:

- designate a coordinator for bioterrorism hospital preparedness planning;
- establish a hospital preparedness planning committee to provide guidance, direction and oversight to the State health department in planning for bioterrorism response; and
- 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, DHS and HHS spent \$3.01 billion in 2002 to fund all of the various components for bioterrorism preparedness nationwide — a 10-fold increase over the \$305 million spent in 2001.

FUNDING TO THE RESCUE

The funding brought many upgrades with it. Hospitals have been able to upgrade infectious disease surveillance and investigation and enhance readiness to deal with large numbers of casualties. Connectivity between hospitals, and city, local and state health departments has been improved,

thus enhancing disease reporting and strengthening public health preparedness. Most facilities conducted readiness assessments and developed surge capacity to deal with mass casualty events, including the expansion of hospital beds, development of isolation and decontamination capacity, identifying additional health care personnel, establishing hospital-based pharmaceutical caches, and providing mental health services, trauma and burn care.

But have these funds been used as effectively as possible? A 2002 General Accounting Office survey of more than 2,000 urban hospitals found that four out of every five had a written emergency response plan that addressed bioterrorism, but most of those plans omitted key information such as contact numbers for local laboratories. The report also points to a lack of regional and statewide coordination in major disaster drills and exercises. Fewer than 50 percent of the hospitals surveyed had conducted drills or exercises simulating a response to a bioterrorism incident. The majority of hospitals also lacked medical equipment essential to deal with an influx of mass casualties. The AHA agreed with most of the report's findings.

PLANNING DISASTER EXERCISES

While there was a general lack of county-wide terrorism exercises in 2002, several large-scale simulations were conducted 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 42 federal, state, county and municipal agencies in a simulated chemical terrorism attack during a large sporting event. Among the goals were to receive and track mass casualties, decontaminate and process victims, and to provide personal protective equipment and proper training to staff.

Even in 2004, as vital as these exercises are to effective preparation, a large percentage of hospitals are still only in the planning stages. The hospital disaster exercises that have been completed have revealed some common recurring problem areas in security. They include:

- communications;
- hospital security;
- decontamination procedures, equipment, and training;
- exercise realism, content and follow-up;
- lack of specific benchmarks for hospitals to use in planning; and
- specific directives from state hospital bioterrorism preparedness planners.

By definition, mass casualty incidents will overwhelm the resources of individual hospitals. The ability to mount an effective response depends on the nature and magnitude of the event. Events that may also disrupt communications and utility services, or require evacuation of hospital facilities, must be considered. Any response requires a high level of coordination among first responders and emergency personnel to be effective. Depending on the 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 is 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 small-scale disasters. Hospital staff must also be protected from chemical or biological agent(s), adding another dimension of complexity for preparedness planners.

Terrorism preparedness is expensive and hospitals are reluctant to create capacity that is not needed on a routine basis and may indeed never be used. The need for additional capacity to respond to bioterrorism emergencies must also be balanced with the need to be prepared for all types of emergencies. Terrorism events still earn a low priority rank in virtually all HVA's (Hospital Vulnerability Assessments). Regardless of the low rank, hospital officials recognize that their facilities are an essential component of terrorism preparedness, and they are planning and training to increase response capacity.

LACKING THE BASICS

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 or 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.

Hospitals are expected to have an adequate supply of personal protective equipment (PPE) and clothing on-hand that includes such items as gloves, gowns, HEPA masks, goggles, shoe covers and level B protection (for front-line employees and custodial staff). Healthcare facilities must also comply with a myriad of government regulations related to patient safety standards promulgated by OSHA and the EPA as well as track and follow mandates, guidelines and directives, such as HIPAA. 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.

BIOTERRORISM PREPAREDNESS¹

Federal Government Funding, 2002-2005 (Dollars in Millions)

| | FY 2002 | FY 2003 | FY 2004 | FY 2005 (Proposed) |
|---|----------------|----------------|----------------|-------------------------------|
| Dept. of Health and Human Services/ Department of Homeland Security (DHS) ² | \$3,019 | \$4,390 | \$5,227 | \$5,734 |
| Health Resources and Services Administration (hospital bioterrorism preparedness) | \$125 | \$498 | \$498 | \$476 |
| Centers for Disease Control ³ | \$949.7 | \$1,046 | \$849.5 | \$1,100 |

National Institute of
Health Biodefense \$1,600 \$1,700
Research Initiative

¹ Bioterrorism preparedness includes preparedness for chemical/nuclear/
biological terrorism

² HHS emergency response became part of DHS in 2003

³ An undetermined amount of CDC funding was applied to bioterrorism
preparedness

**SOURCE: GAO-04-360R - HHS Bioterrorism Preparedness
Programs; HHS Fact Sheet: Biodefense Preparedness; News Release,
April 28, 2004**

FOR THE RECORD...

ABOUT THE AUTHORS

Jeff Aldridge, CPP, president of Security Assessments Intl., is a healthcare security expert with more than 25 years experience in law enforcement and hospital security. Since founding SAI, he has assisted more than 600 hospitals in all aspects physical and patient security, and consulted with national and international R&D companies in the design and development of state-of-the-art security products for the healthcare industry. Phillip Launt is SAI's director of business development.

ACKNOWLEDGMENTS

The following people helped to prepare this article:

Melissa Sanders, chief, National Bioterrorism Hospital Preparedness Program, HHS/HRSA

Alison Johnson, acting director, Division of State and Local Preparedness, Office of Terrorism Preparedness and Emergency Response, CDC

Erica Froyd, senior legislative analyst, Association of American Medical Colleges

[Want to use this article? Click here for options!](#)

© 2004, PRIMEDIA Business Magazines & Media Inc. 

[Back to Top](#)

Key: [★] Paid Content [+] Enhanced for the Web

[Contact Us](#) [For Advertisers](#) [For Search Partners](#) [Privacy Policy](#) [Subscribe](#)

© 2005 Primedia, Inc. All rights reserved.