American Hospital Association

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Via email delivery:

July 11, 2008

Emily S. Miller
SRA International
Partnership and Outreach Division
Department of Homeland Security
Washington, DC

Dear Emily:

On behalf of the American Hospital Association (AHA), we are submitting the following comments on the Homeland Security Advisory System (HSAS) for Healthcare and Public Health Sector (as updated 02-25-2008).

The disasters our nation faced in the last seven years, from the 2001 terrorist attacks to the Gulf Coast hurricanes, to the most recent flooding in the Midwest, have redefined the meaning of disaster readiness for the nation, communities and hospitals. Over this time period, as the nation has focused on strengthening our national security and emergency readiness, America's hospitals have been upgrading existing emergency operations plans and integrating these plans with their local response structure. They continue to tailor their plans to suit the individual needs of their communities in the face of new and emerging threats.

While the AHA continues to support the organizing components of the HSAS, we have learned that hospitals respond to disasters somewhat differently than is outlined in the HSAS. Most importantly, hospitals believe that a five-stage alert and response system does not fit with the way in which hospitals respond to disasters. We outlined our thoughts on this issue in a 2002 letter to the Honorable Tom Ridge and are attaching this earlier letter to this correspondence as the points are still relevant.

With regard to your more recent request for comments about the Homeland Security Advisory System (HSAS) for Healthcare and Public Health Sector (as updated 02-25-2008), we discussed it on a conference call with hospital association preparedness staff from across the nation. The following concerns were raised:

- The document was last updated on February 25 but not shared with the private sector until June 28 with less than two weeks to comment, including a national holiday weekend. The four month delay in sharing the document is unacceptable. If DHS genuinely seeks field input, a longer comment period must be provided.

- The introduction material on "How to Use the Guidance Template" states that it is a "non-prescriptive reference for owner-operators to use to capture and refine new or existing sector actions taken when the threat level changes." The field is concerned that this qualifying language will be ignored and the "catalogue of potential protective actions" will become a requirement for federal grants or a standard used by courts to assess negligence.

- The "planning assumptions" on the first page include the statement that "the duration of an elevated threat status (Orange, Red) will be finite and short lived Time at the Orange threat level will be measured in weeks not months, and in the Re level in days and not weeks." This is not consistent with the long-standing aviation threat level of Orange and the field would welcome a strong statement that a long-standing Orange threat level will not be applied to health care because of its disruption on the effective and safe operation of hospitals.

- The identification of the Yellow threat level as the "baseline" implies that there never will be a Green or Blue threat level. If five levels have now become three, the base or Yellow level needs to be much less comprehensive and less detailed.

- The threat levels and suggested actions listed in the document are not consistent with state-specified levels or recommended actions of the HavBED requirements.. It is important to harmonize the document or to acknowledge that state level actions have precedence in a tiered National Response Framework that identifies local and state emergency operations as the first two tiers.

- The document may be read to imply that moving to an elevated threat level is nationwide. No provision is acknowledged for local or regional threat levels.

- The Baseline Countermeasures for Personnel include the following: "conduct a background check on all employees." This is extra-ordinarily expensive in a field where many persons work part-time and where others frequently change employers. More significantly, as communities have developed offender rehabilitation programs with the hospital as employer, the suggested background check threatens to undermine the success of these programs.

- The document fails to recognize that maintaining open access to the hospital for patients, visitors, and caregivers is a critical success factor in their operation. The access controls components are unacceptable and need to be reconsidered and reduced.

- The costliness of the guidance undermines the safe, efficient, and effective operation of hospitals by presuming that critical infrastructure protection is their primary purpose and has unlimited financial resources. For an administration that controls pricing for the largest segment of the patient population and that has repeatedly recommended cuts in payment, the listed items are unrealistic.

- Finally, within the health care field, some hospitals are large organizations with substantial staffs and resources. Many other components of the field, such as small hospitals, critical access hospitals, community health centers, and physician practices, are much smaller and have very limited resources. To suggest that that owner-operators should take the actions listed is so excessive as to invite ignoring a more honed and focused list.

The AHA appreciates the Administration's efforts to improve the coordination and communication among all levels of government and the American public in preparing and responding to disasters. Hospital caregivers perform heroic, lifesaving acts every day. And, in the face of the unexpected, they will rise to meet the needs of their communities.

On behalf of the nation's hospitals, the AHA is committed to working with the Departments of Homeland Security and Health and Human Services and other agencies and departments of the federal government to ensure that the nation's hospitals continue to fulfill their critical role in planning for and responding to all types of disasters in the communities they serve.

If you have questions regarding our comments, please do not hesitate to contact me or Roslyne Schulman, senior associate director for policy development, at (202) 626-2273 or at rschulman@aha.org.

Sincerely,

James Bentley, Ph.D.
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