



# The Hands of Mercy

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## Editor's Notes

By James D. Hessman, Editor in Chief



An assassination in London, a four-stories-tall training simulator in New York City, a controversial border fence in Arizona, and a seven-state Depression-era leftover that might well be the most valuable piece of critical-infrastructure real estate in the entire world. All are among the topics covered in this special February issue of *DomPrep Journal* – which also includes detailed reports on the complicated but vitally important “Gap Analysis” process, the pros and cons involved in the proposed establishment of a so-called National Fire Insurance program, and Virginia’s best-practices approach to public-health and disaster planning. In addition:


(a) Kay Goss tells the still little-known story of how three retail-industry giants – WalMart, Home Depot, and Lowe’s Home Improvement – leaped into action in the aftermath of Hurricane Katrina, bringing not only essential supplies but also some much-needed emotional relief to the wet and bedraggled survivors of that historic catastrophe – and, not incidentally, providing a best-practices example to the federal, state, and local governments also involved (but not as rapidly or as efficiently) in the recuperation and recovery process.

(b) Theodore Tully discusses the slow and sometimes painful evolution of hospital emergency-room planning from one-incident/one-victim situations to preparing for simultaneous incidents with multiple victims to today’s federally mandated focus on mass-casualty scenarios involving numerous political jurisdictions and hundreds of possible victims across a multi-state area of the country.

(c) Steve Grainer spells out the numerous and compelling reasons why all responder agencies, at all levels of government, must develop detailed Incident Action Plans, test them out thoroughly and frequently, and train their personnel – through repeated drills and exercises – to follow those plans as closely as possible in the real-life situations and scenarios coming their way (but not always at the time or in the place expected).

As in all of *DPJ*’s previous printable issues, each article in this issue stands alone, on its own merits. Each was written by a highly respected career professional with years of operational, supervisory, and/or management experience in one or more of the several specialized disciplines that come under the homeland-security/domestic-preparedness “umbrella.” And each is part of a much larger mosaic that is still under construction, still being changed, altered, and revised in various ways to meet new needs suddenly perceived, and still growing in both political and economic importance, in its relevance to the daily life of the American people, and in its rapidly growing capabilities to preserve, protect, and defend those people and the U.S. homeland.

*E Pluribus Unum* applies not only to the states and territories that make up the United States – and to the individual armed services, including their national guard and reserve components, that make up the U.S. defense establishment. That sacred slogan applies with equal force and validity to the numerous agencies and organizations – at all levels of government and in the private sector as well – that make up this nation’s homeland-defense force. Firefighters; emergency managers; policemen and other law-enforcement personnel; doctors, nurses, EMTs, and other medical professionals; and, last but not least, the private-sector inventors, designers, and builders of the hundreds of sensor systems, protective clothing, and other equipment items now entering the homeland-defense inventory on an unprecedented scale – all are members of the same team.

And they all deserve the admiration, respect, and undying gratitude of their countrymen. We are proud to salute them in this and every other issue of the *DomPrep Journal*. 

*About the Cover: Members of the U.S. Air Force’s 354th Medical Group assist an injured bystander during an emergency-management exercise carried out last summer at Eielson Air Force Base, Alaska. (U.S. Air Force photo by Airman 1st Class Christopher Griffin.)*

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## Anatomy of a Near-Miss Radiation Disaster

By Michael Allswede, Public Health



In the literature of quality management, a “near miss” is described as an event that might have had terrible consequences but did not – because they were averted by alert personnel, by the discovery of something unusual and/or unexpected, or by simple happenstance. Many quality management personnel have suggested that their most common response to a near miss is to feel thankful and to move ahead.

For the more astute, however, a near miss serves as the trigger for a “near-miss analysis.” New policies and processes to prevent a future calamity usually would be the principal benefits that would result from that analysis. One of the best examples of near-miss analyses, followed by quality improvements, has been set by the major airlines of the world. Although airline crashes still occur, systemic failures that are investigated and found to have been preventable are aggressively corrected.

### *The Litvenenko/ Polonium 210 Incident*

On 1 November 2006, a previously healthy 43-year-old male became suddenly ill and was taken to a local medical facility. His initial illness was thought to be a form of food poisoning from a sushi meal he had eaten earlier that day. Instead of the improvement expected after his hospitalization, the man became gravely ill – because, it was later determined, his bone marrow failed to produce red and white blood cells; he also suffered from continuous bloody diarrhea and vomiting, and required several transfusions.

Several medical specialists were consulted and many theories were

ruled out. Only after the man had lost his hair were his own claims of an attempted assassination heeded. After additional testing, Polonium 210 was found in the urine of Alexander Litvenenko, a former KGB colonel and an outspoken critic of then-Russian President Vladimir Putin. Litvenenko died on 22 November 2006.

Polonium 210 is an extremely lethal radiation isotope that emits only alpha particles. The alpha particle is the largest form of particulate radiation but, because of its low penetration capabilities, is not considered a “contact” risk. However, it is a high-grade risk when ingested or inhaled because, once it is in the human blood stream, the alpha particle wreaks great damage on the cells with which it comes into contact.

Polonium 210 is 250,000 times more toxic than cyanide. It also is an isotope that does not occur naturally. It can be produced, though – but only in small quantities – by bombarding Bismuth 209 inside a nuclear reactor. Polonium 210 rapidly degrades to lead, and has a half-life of 138 days. For practical, including forensic, purposes, that means that within about one year it becomes very difficult to detect within a human body. Making detection even more difficult is the problem that alpha particles are *not* detected by a standard Geiger-Mueller counter; more specialized and considerably more expensive equipment is needed. The world’s leading producer of Polonium 210 is Russia.

### *Delayed Recognition And Contamination*

Following the discovery of high levels of Polonium 210 in Litvenenko, British law-enforcement, health, and intelligence authorities investigated

the possibility that Litvenenko had been intentionally exposed. These efforts resulted in the discovery – on 26 January 2007, almost three months after the attack – of a tea pot from the Millennium Hotel that was highly contaminated with Polonium 210. The current theory is that the tea was intentionally contaminated by a Russian agent named Andre Lugovoi, whom Litvenenko met in London on 1 November 2006. In the 87 days that

had passed between that date and the discovery of the contaminated tea pot, several airlines and their employees (plus passengers), a number of hotel employees, and an unknown but possibly very large number of private citizens may also have been exposed to the deadly isotope.

The case of Alexander Litvenenko's murder demonstrates the need for a forensic epidemiology system – or,

preferably, an international network of such systems. What in Litvenenko's case was a deadly disease represents a simultaneous public-health emergency, a hazardous-materials event, a crime, and possibly an act of war. Although only Litvenenko is known to have suffered adverse effects from the 2006 poisoning, the situation may well have been quite different – *if* the isotope had been more toxic; or *if* Litvenenko had expelled the isotope more rapidly; or *if* the possibility of Polonium 210 was not considered a “possible cause” by the physicians treating Litvenenko.

Although no one person might have understood all of the facts and information that eventually resulted in this case being recognized for what it was, the ability of experts in different fields to communicate across a broad range of professional disciplines was the key to arriving at the eventually correct diagnosis. Rapid access to all of the information that might be needed – with appropriate safeguards built into the system – is and should be the core of a reliable and effective forensic epidemiology system.

Footnote: At least one intelligence source has suggested that almost 80 percent of Russia's senior government officials were associated in one way or another, earlier in their careers, with the former Soviet KGB or Russian FSB (Russian Security Agency). The most prominent of those officials, of course, is Putin, who was once the director of the KGB. Which leads to a relevant question: If the murder of Litvenenko was in fact carried out by Russians, how many other Polonium 210 murders may have been committed in recent years that have gone undetected because of the lack of a forensic-epidemiology network?

*Dr. Michael Allswede is director of the Strategic Medical Intelligence Project on Forensic Epidemiology and the creator of both the RaPiD-T Program and the Pittsburgh Matrix Program for hospital training and preparedness. He also has served on a number of expert national and international groups in the preparedness field.* ▼

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# Incident Action Planning: Staying the Course

By Stephen Grainer, Fire/HazMat



Emergency responders throughout the United States have been working diligently since 2006 to meet the most current compliance criteria for completing intermediate and advanced Incident Command System (ICS) training. The ICS training stipulated in NIMS (the National Incident Management System) compliance criteria includes the course “Intermediate Incident Command System for Expanding Incidents” – also known as ICS-300. The U.S. Department of Homeland Security (DHS) has determined that middle managers and supervisors, including unit leaders, must complete training to the ICS-300 level by the end of fiscal year 2008. The target date for that training to be completed is 30 September of this year. To meet that goal, tribal entities, local emergency responders, state government agencies that have been assigned emergency-response duties, and other agencies and organizations are working vigorously to: (a) identify the specific personnel who need the training; and (b) ensure that those personnel are trained to the required level by the target date specified.

At the root of the ICS-300 training is the principle of training personnel to be prepared to manage the previously mentioned “Expanding Incident” – which is defined as one in which the resources usually available to cope with most emergencies are unlikely to be capable of achieving the desired level of control for the incident at hand. ICS-300 provides training in a number of topic areas not previously developed in either ICS-100 (“Introduction to ICS”) or ICS 200 (“Basic ICS”).

Notably, there are two important units in ICS-300 – “Resource Management” and “The Planning Process” – that provide the student with the training specifically

needed to manage an expanding incident. Those two units serve as an essential foundation for the mass of knowledge needed for developing and following a comprehensive Incident Action Plan (IAP). The ability to develop, implement, and monitor an IAP is the most critical element in effectively managing *any* major incident – but becomes even more critical when an incident grows in size, scope, and/or complexity.

## Q&A, Plus IAPs and SOPs

The most important question asked by many ICS 300 students is both reasonable and simple: “When should an Incident Action Plan be used?” The answer is equally reasonable, and even more simple: “*Always.*”

However, it must be pointed out that in a theoretically “routine” emergency, and/or other relatively common situations, it is usually not necessary to create a *written* IAP. Most typical incident-response operations are carried out in accordance with standard operating procedures (SOP) that are based on repetition and success and have been developed over a long period of time. For example, firefighting, EMS (emergency medical services), law-enforcement, public-works, and public-health agencies – and a broad spectrum of other agencies and organizations (the highway department, for example) – typically respond to emergencies and other situations that crop up almost every day with a “standard” resource contingent and conduct their operations in a similarly “standard” way. These situations are met and (in an overwhelming majority of cases) resolved by using procedures that generally have been proven successful over a period of years. Which, of course, is why they have been designated as the “standard” way to meet similar situations in the future.

Moreover, although the specific incident manager (foreman, supervisor, officer, etc.) on the scene usually has the flexibility needed, in most if not all cases, to adjust and adapt to the specific conditions encountered in any single incident, the standard operating procedures prescribed for that type of incident typically provide the organizational and operational framework needed for bringing about a successful conclusion. In perhaps 90 percent of responses, in fact, the incident is over before enough time passes even to draft a written IAP. Therefore, although the response is managed in accordance with IAP guidelines, a specific plan addressing the procedures that should be followed to deal with a specific ad hoc situation is seldom written.

Instead, the procedures followed during most if not quite all emergency situations that suddenly develop simply flow naturally from an intellectual or mental plan coordinated by the incident commander on the scene and carried out according to standard operating procedures. This is as it should be, because time is of the essence in coping with most emergencies, and the more time that passes the worse a specific situation becomes. Which is another excellent reason why responder units and individual responders must learn and practice standard operating procedures until SOP becomes all but automatic – somewhat like breathing.

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*Stephen Grainer is the chief of IMS programs for the Virginia Department of Fire Programs. He has served Virginia fire and emergency services and emergency management coordination since 1972 in assignments ranging from firefighter to chief officer. As a curriculum developer, content evaluator, and instructor, he currently is developing and managing VDFP programs to enable emergency responders and others to achieve NIMS compliance requirements for incident management.*

*The VDH Example****Public-Health Planning: Partnerships Work****By Steven Harrison, Public Health*

Since the Congressional passage of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, the nation's public-health community has made tremendous improvements in its emergency-response capabilities. The terrorist attacks of 11 September 2001, the anthrax attacks shortly thereafter, hurricanes Isabel and Katrina, and the early warnings of a possible influenza pandemic were instrumental in underscoring the need for the presence of public-health representatives at the proverbial "planning table."

In the Commonwealth of Virginia, the need for public-health officials to collaborate with non-health partners in preparedness efforts is recognized and understood as key to the success of the initiatives developed. Plans for the distribution of emergency medical supplies and pharmaceuticals through the Strategic National Stockpile (SNS) program, for example, are in place and routinely practiced. The federal government's NIMS (National Incident Management System) and ICS (Incident Command System) principles are embraced as effective tools for the management of infectious-disease outbreaks and for a broad and varied spectrum of such other health-related events as the evacuation of medically fragile patients, drinking water infrastructure failures, the spread of foodborne diseases, and weather catastrophes such as floods and hurricanes.

Interoperability and collaboration are key components in the Commonwealth's planning decisions. As an example, Virginia, like many other states and territories, participates in the federal government's Chempack Program.

This program is administered through the CDC (Centers for Disease Control and Prevention) and public-health agencies, but involves both public and private sector stakeholders. A guiding principle of Chempack is that caches of nerve-agent antidotes must be forward-deployed for immediate use in the event of a nerve agent attack. In view of the expediency required for effective antidote administration, adherence to this principle demands that clear and concise protocols be developed across agency as well as jurisdictional lines.

***A guiding principle  
of Chempack  
is that caches of  
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use in the event of a  
nerve agent attack***

***Pre-positioning Medical Assets  
And Special Needs Planning***

In addition to these examples of partnerships in action, the Virginia Department of Health (VDH) has developed an assortment of strategies to engage the department's SNS partners and community stakeholders on the pre-positioning of local pharmaceutical caches that may be needed to give citizens protection from exposure to a biologic agent. Among the many related issues discussed and in most cases resolved were the development of policies on first-responder/first-receiver and

head-of-household dispensing, the alternative modalities needed to expedite community mass prophylaxis efforts, the preparedness efforts needed to cope with a pandemic influenza, sheltering and evacuation plans for the technologically dependent and/or special medical needs populations, and communications interoperability – all of which require, in the implementation stage, not only close collaboration but also a mutual understanding of the response roles of other agencies and organizations involved in the collective response.

VDH's close working relationship with the Virginia Fusion Center also demonstrates the department's strong support for inter-agency cooperation and information sharing. The Fusion Center, with which VDH communicates routinely (often daily), is essential to Virginia's homeland-security efforts and serves as the primary resource for the exchange of critical information between and among local, state, and national homeland security, law-enforcement, and intelligence agencies.

Today, a collaborative environment exists in which a broad spectrum of organizations and agencies – including but not limited to local and state emergency management, firefighting, law enforcement, and EMS (emergency medical services) agencies as well as the National Guard and numerous non-profit, faith-based, and volunteer organizations – all participate in varying degrees. Just as important to the collective effort are such private-sector businesses as pharmacies, transportation companies, manufacturers, hospitals, community health providers, and many others.



## The Varied Voices Of Other Stakeholders

Virginia also enjoys the strong support of various health initiatives and inter-agency collaborations promoted by and/or through the Governor's Office, the Office of Commonwealth Preparedness, and the Commonwealth's Secretary of Health and Human Resources. A late January meeting among federal representatives – from the Department of Health and Human Services (HHS), the Federal Emergency Management Agency (FEMA), the Department of Defense (DOD), state and local agencies (in the public health, emergency management, and transportation fields, primarily), private health providers (hospitals and nursing homes) and such professional organizations as the Virginia Hospital and Healthcare Association and the Virginia Health Care Association – further demonstrated the important value of the partnerships, and professional relationships, already being developed.

The January meeting – which was convened to work on mutually acceptable pre-hurricane “landfall” decision-and-deployment timelines for the Hampton Roads area – was particularly important because it fully engaged policy planners and decision-makers in open-ended discussions of differing and sometimes competing local, state, and federal planning assumptions.

Those discussions also revealed that, on a number of important matters, the concepts of operations followed by the various agencies represented were not always in alignment. Nonetheless, attendees came to a closer appreciation not only of one another's roles but also of the reasoning behind existing (and sometimes differing) policies on trigger points and implementation strategies. Future meetings are planned over the coming months to resolve

various inconsistencies that have been identified.

Through these and other closely related efforts, VDH has emerged, and is participating, as a strategic partner in planning and multi-agency coordination for all-hazards events at the federal, state, regional, and local levels.

Steven A. Harrison is the assistant director – emergency operations, logistics, and planning

– for the Commonwealth of Virginia's Department of Health. His principal duties involve: (a) various tasks related to and/or requiring a working knowledge of both Chempack and the Strategic National Stockpile; and (b) execution of Virginia's own Hurricane Preparedness and Exercise Program. He also collaborates with other policy makers and decision making officials on the Cities Readiness Initiative and State Managed Shelter planning. Harrison, a graduate of the College of William and Mary, also holds a Master Exercise Practitioner certification and is pursuing a Master's Degree in Homeland Security.

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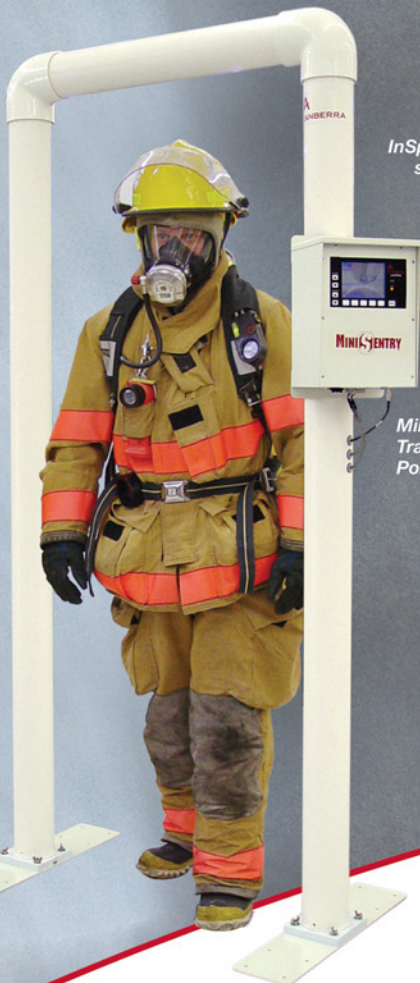


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## U.S. Businesses Respond to Community Needs

By Kay C. Goss, Emergency Management



For more than two centuries the American people have responded well and capably to a broad spectrum of emergencies of all types ranging from weather disasters to invasions and other military attacks to medical pandemics to explosions, plane crashes, and floods, famines, and forest fires. Today, the nation's federal, state, tribal, city, and county emergency-response capabilities are distributed throughout a long-established system of systems that U.S. citizens know they can always rely on to come to the fore in times of their country's – or their individual community's – greatest need.

It is sometimes forgotten, though, that over that same period of time the nonprofit sector also has played a key role in responding to the same emergencies. The Salvation Army, the American Red Cross, the United Way, Catholic Charities, the Jewish Federation, the National Council of Churches, the Interfaith Alliance, the Southern Baptist Convention, Mennonites, the United Methodist Churches, AME Churches, and many other organizations also are well known for their individual as well as collective preparedness, response, and relief efforts.

However, after the catastrophic 2005 hurricane season, the nation saw not only the federal, state, and local governments – the Federal Emergency Management Agency, the State of Louisiana, and the City of New Orleans, primarily – but also the nonprofit organizations struggle to get their operations up and going. The numerous and sometimes inexplicable delays experienced in the aftermath of Hurricanes Katrina and Rita, in particular, were caused in part by problems in communications and

coordination, in part by a lack of transportation and of pre-positioned emergency supplies, and in part by simple human error. Fortunately, the void that followed was filled, at least in part, by various pro bono initiatives developed and carried out by another major component of the private sector, the U.S. business community.

### **Three Cheers For Three Retail Giants**

A number of best-practices efforts are worthy of special mention. In the wake of the two devastating hurricanes, Wal-Mart won praise and recognition for

***Wal-Mart  
and other businesses  
provided early relief  
at a time when public  
and nonprofit  
emergency-response  
agencies were still  
getting started***

the company's handling of emergency operations along the Gulf Coast. Under the leadership of Jason Jackson, Wal-Mart's emergency management director, the company's Emergency Operations Center in Bentonville, Arkansas, became a national hub of response activities, providing water, toiletries, transportation, food, clothing, and many other necessities throughout the hurricane-devastated areas of the Gulf Coast. Although the company is not a first-responder agency per se and its employees were and are not local emergency managers by any means,

Wal-Mart and other private-sector businesses provided key early relief during the recovery process at a time when the officially designated public and nonprofit emergency-response agencies were still getting started.

Home Depot also stepped forward by providing generators, flashlights, batteries, plywood, and numerous other products essential to a speedy recovery. The Home Depot managers and warehouse employees pulled countless tons of building and repair products off their shelves to supply the hurricane-devastated areas in greatest need. The company also created so-called "strike zones" where specific needs were known and transported associates to those areas to help out the associates already on the scene and working furiously in the communities hit hardest by the hurricanes and subsequent flooding.

Lowe's Home Improvement, which also has a long history in emergency-preparedness responses and operations, conducts disaster-assistance workshops on how to prepare for, respond to, and mitigate the worst aspects of disasters such as spring flooding. For many years Lowe's also sponsored the Home Safety Council – which now has many other sources of funding, all following in the footsteps and deep impressions made by Lowe's employees and managers.

### **Messages of Hope, Counterparts of Kindness**

After Katrina, federal, state, and other public emergency-management officials observed, and commented favorably on, the Wal-Mart, Home Depot, and Lowe's messages on radio stations throughout Arkansas, where there were close to 100,000 evacuees. One of the most important of those messages told the evacuees who had

worked for any of the three companies in Louisiana or Mississippi to report for work at those same companies' counterpart stores in Arkansas. The implementation of that brilliant initiative contributed significantly to the recovery not only of numerous individual families but also, eventually, their original home communities.

These three examples represent a larger corporate/good-citizen response capability that is setting a new national standard for service and community involvement. Certain types of businesses almost immediately become a critical component of a community's emergency-management infrastructure in times of disaster, because they can provide pharmaceuticals, food, water, dry goods, toiletries, lumber, tarps, flashlights, hammers, nails, saws, generators, paint, and thousands of other products needed not only on an everyday basis but also – quickly and in large quantities – in sudden times of emergency.

Some states already are recognizing the important new role being played by the private sector. In Florida, for example, former Governor Jeb Bush authorized the use of temporary emergency identification and access credentials for certain retail employees, allowing them to cross disaster barricades to deliver supplies and/or to secure stores from looting – or, in some locales, to open stores for business (if law-enforcement personnel in Florida know in advance, and in specific situations, that a truck with a certain placard will be delivering critical supplies).

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## ***A Burning Question: National Fire Insurance?***

*By Joseph Cahill, EMS*



For the past several months the nation's print and broadcast media have taken breaks from their coverage of the 2008 presidential elections to report from time to time on the massive destruction caused by the West Coast wildfires. There has been tale after tale of lost homes, and many articles focusing on the massive cost of replacing or rebuilding the lost homes. Many of the home owners interviewed had no insurance and were unsure of how, and if, they would be able to rebuild.

Creation of a national program of wildfire insurance is one option that has been mentioned to ensure that the huge financial investment so many Americans make in their homes can be reasonably secure and that they can at least be assured of being able to rebuild. In that context, it is worth pointing out that wildfires and floods share certain features in common, including: (a) hazard predictability on the local level; (b) the loss of a large number of homes in a single event; and (c) the involvement of a significant number of uninsured homeowners.

At least in part because of its own annual wildfire losses, California has taken the lead in exploring several innovative response possibilities, including the creation of a statewide mutual-aid system and a "firescope" program – similar in many respects to the federal government's incident command system (ICS).

Among the several working tools available not only to firefighting agencies but also to land-use

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planners in California is a set of "fire risk" maps maintained by the state's Department of Forestry and Fire Protection, Fire and Resource Assessment Program. Such maps, which plot the relative fire risks in the state's forests and rangelands, can be a major resource in the development of financial plans and insurance programs related to risk assessments.

### ***Zone Mapping, And the FEMA Template***

Some experts have suggested, in fact, that fire-hazard mapping probably should be expanded nationwide, so that all inhabited areas of the country would be mapped into wildfire zones. Such mapping would take into account not only historical data but also such relevant current factors as the types and varieties of plant and tree growth in the area being mapped. The configuration of the land and the water resources available (for firefighting, at least) would be among the other factors that should be taken into consideration.

The Federal Emergency Management Agency (FEMA) has provided a helpful template that could be used by separating the entire United States into "flood zones" that are divided primarily by the relative degree of flood risk within each zone. Like flood zones, wildfire zones would show at a glance the areas of the country where fires are more likely to occur over a given period of time, and would be an extremely useful risk-analysis tool.

There is another similarity between floods and wildfires that is worth taking into consideration – namely, that not only homes but entire neighborhoods can be lost in a wildfire, just as they are in a flood. That cruel fact of modern life is a compelling reason why a national wildfire insurance program is worth considering. The impact that such

events have on the community is almost incalculable when large numbers of homes are lost at the same time and their owners are left to struggle with the frequently impossible costs of rebuilding.

A final point of similarity between floods and wildfires is that there are certain mitigation steps that can be taken to lessen not only the risk involved in either calamity but also the potential financial loss that would be incurred. These steps would only *lessen* the risks and/or financial losses, it should be emphasized, not completely eliminate them.

In that context, it would seem both logical and appropriate for the federal government not only to partially subsidize the insurance required but also to mandate its purchase by those

who choose to live in high-risk areas. Too often in the past – particularly in high-risk flood areas – it has been left to the federal government to provide the safety net needed by homeowners who did not or could not purchase hazard insurance. A better answer to the politically difficult question of how to help support those who live in high-risk wildfire areas may not be continued federal disaster assistance but a subsidized insurance plan mandated for those who choose to live in areas of high risk.

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*Joseph Cahill is currently a Medico legal investigator for the Massachusetts Office of the Chief Medical Examiner. He also worked as the Exercise and Training Coordinator for the Massachusetts Department of Public Health - Center for Emergency Preparedness - and as an emergency planner in the Westchester County (NY) Office of Emergency Management, and served as a line paramedic for over ten years in the South Bronx and North Philadelphia.*



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*A Best-Practices Example****TVA and Protection of the Critical Infrastructure****By Adam Montella, Law Enforcement*

The Tennessee Valley Authority (TVA) serves as a leading-edge case study for coordinating efforts between private-sector security forces and public law-enforcement agencies for critical infrastructure protection (CIP). Officials accept that CIP is a shared responsibility between both public agencies and private-sector businesses and other stakeholders. However, because most of the nation's vital services – water and electrical power, for example – are delivered by private companies, there is a significant challenge in determining which private-sector company, or government agency, has the responsibility of protecting a specific component of the nation's critical infrastructure.

TVA has a wealth of experience in dealing not only with the regulatory issues involving private-sector organizations that span a number of states but also with the cost and other financial problems resulting from unfunded mandates created by the issuance of various federal regulations or presidential directives. The TVA approach may therefore apply, as a best-practices example, to other critical-infrastructure entities facing similar regulatory and funding challenges.

TVA came into being in 1933 as “a corporation clothed with the power of government but possessed of the flexibility and initiative of a private enterprise.” Like many critical infrastructures owned and operated by the private sector, the TVA facilities are among the nation's most important infrastructure assets – and actually a fairly large part of the national infrastructure. The TVA “footprint” is both vast and vulnerable. The Authority sells power to 158 local distributors that serve an estimated 8.7 million

people and 650,000 businesses and industries in the seven-state TVA service region that covers almost all of Tennessee and sizable areas of Alabama, Georgia, Kentucky, Mississippi, North Carolina, and Virginia.

***Each difficult issue the Authority faced – whether it involved power production, navigation, flood control, malaria prevention, reforestation, or erosion control – was studied in its broadest context***

***A Diverse and Powerful Portfolio of Tangible Assets***

TVA also sells power to 59 large industrial customers and federal installations. The Authority's power system consists of a diverse mix of fuel sources, including fossil, nuclear, hydro, and renewable. Its physical inventory includes 11 coal-fired and eight combustion-turbine plants; three nuclear plants; 29 hydroelectric dams; and one pumped-storage plant as well as 16 solar power sites, one wind power site, and one methane gas site. Thanks to these resources, TVA generates more electricity than any other public utility in the United States.

From its inception, TVA used a unique problem-solving approach in carrying out its mission. Each difficult issue the

Authority faced – whether it involved power production, navigation, flood control, malaria prevention, reforestation, or erosion control – was studied in its broadest context. TVA weighed each issue in relation to the others to find the best possible solution to one that would not cause problems in other areas. Since its beginning, TVA held fast to its strategy of developing integrated solutions, even as the issues it faced – including some involving U.S. national defense and homeland security – changed over the years.

In the 1990s, TVA anticipated the issuance of presidential directives governing the protection of critical infrastructure. A 1996 Executive Order (13010) pointed out, for example, that it is essential for the government and private sector to work together to develop a strategy for protecting critical infrastructures and ensuring their continued operation. The problem, though, was determining *how* to best protect the Authority's vast complex of critical infrastructure facilities in a broad geographic area covering seven states.

It should be noted that, even prior to the signing of Executive Order 13010, TVA recognized that it had not always been totally effective in providing consistent protection for all of its facility sites. Each of the seven states it served had different regulations and procedures for coordinating with law-enforcement agencies. To overcome that challenge, TVA petitioned the federal government in 1995 to “reclassify” its private security guards by making them federal police officers. That foresighted petition was granted and one result was that TVA officers can now enforce local and federal laws in all seven of the TVA states.

### **Cooperation, Coordination, and Partnerships**

But TVA did not stop there. According to DeWane Broome, the TVA police's commander of field services, the Authority has further strengthened its relationships by participating in Joint Terrorism Task Forces (JTTFs) with local and federal law-enforcement agencies and by serving on the Tennessee Valley Anti-Terrorism Advisory Council (ATAC). "Becoming federalized police and participating with local and federal law-enforcement agencies in task forces and councils has allowed us to be more effective in protecting our infrastructure," said Broome.

Despite the success of TVA's efforts to protect its infrastructure, it still has a number of major challenges to overcome – one of the most important of which is obtaining the additional budget resources needed to be compliant with the unfunded mandates issued by the federal government, particularly since the terrorist attacks in September 2001. "We are still faced with many of the same problems ... [facing] private industry," Broome said.

It is fair to point out that the Authority also faces *some* funding problems that are of little or no concern to the private sector. The federal regulations and presidential directives issued to improve protection of the critical infrastructure often but not always have some rather large price tags attached. However, like many other public utilities across the country, the TVA is not eligible to receive grants from the U.S. Department of Homeland Security (DHS) that would help offset the costs of compliance. "We are required to participate in the threat and vulnerability assessments for critical infrastructure facilities with our states, counties, and municipalities," said Broome, "but receive no funding to conduct the assessments or to take action based on the findings."

TVA has determined – to cite one example of how success breeds success, even when private/public partnerships are involved – that it is more cost-effective to have contracted security guards, rather than its own police officers, protecting TVA's own nuclear facilities. Although it may appear at first glance that TVA may have left a gaping hole in its protective armor, the security forces are actually armed and have police powers on the TVA grounds that they are guarding. They also are supported by TVA's own police, who usually are stationed at neighboring sites in close proximity. A specific situation in which this cooperative arrangement was put to good use was during a recent protest at one of the Authority's nuclear sites, where TVA police and the Pinkerton security guards set up a dual barrier around the facility – with the TVA police working outside the fence and the Pinkerton guards inside.

### **Raising the Funds, Lowering the Barriers**

TVA's jurisdictions fall into four "umbrella" categories – Federal, Proprietary, Concurrent, and MOU (Memoranda of Understanding). The specific category assigned usually depends on such factors as what agency or political jurisdiction owns the land where the TVA facility is located, and/or the agency's ability to prosecute within a locality's jurisdiction.

TVA is financially self-supporting – another way of saying it receives no funding from taxpayers. One possibility that TVA is looking at to obtain the financial resources needed to pay for unfunded regulations and mandates could be to follow the example set by the Port Authority of New York and New Jersey (PANY&NJ), which in 2004 solicited assistance from the Office for Domestic Preparedness (ODP) of the U.S. Department of Justice. Although the City of New York and the States of New York and New Jersey were eligible for, and were receiving, millions of

dollars in support, equipment, and training funds, the PANY&NJ – which was headquartered at the World Trade Center, and which owned and operated its own facilities – received no federal funds, even following the terrorist attacks of 11 September 2001.

ODP provided the technical assistance and contractor support needed to help the Port Authority develop a toolkit for special jurisdictions. According to John Paczkowski, the PANY&NJ director of operations and emergency management, the toolkit "assisted the Port Authority in assessing all its critical infrastructure facilities for threat, vulnerability, and criticality," and the findings of that assessment "formed the basis for our justification to receive grants and other funding."

The justification paved the way in turn for the Port Authority to be written into the definition of the Urban Area Security Initiative (UASI) for New York City in 2007 not only as a principal agency but also, and of greater importance, one that is eligible to receive federal grant dollars. That elegant solution proved, if nothing else, that the best types of good examples are those that can run in either direction on the two-way street of public/private-sector cooperation and coordination.

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*Adam Montella is vice president of homeland security and preparedness services for Previstar Inc. and a nationally known emergency-management and homeland-security professional with more than 23 years direct experience in both government and the private sector. He served as the first general manager of emergency management for the Port Authority of New York and New Jersey in the period following the 11 September 2001 terrorist attacks and has served in many other emergency-management positions at all levels of government. A former member of the House Operations Recovery Team of the U.S. House of Representatives and of numerous local, state, national, and international emergency management associations, he also is a well known public speaker in his chosen field and a former recipient of Harvard University's prestigious Innovations in American Government Award. ▼*



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## Gap Analysis – A Long and Winding Process

By James M. Rush, Public Health



One of the most important working tools available to any healthcare organization is a comprehensive, reasonably workable, and not overly complicated Emergency Management Program (EMP) – which itself should include an equally comprehensive “Gap Analysis” section that spells out, in considerable detail: (a) anticipated future requirements; (b) current shortages and deficiencies; and (c) the additional resources needed to ameliorate or, preferably, eliminate the deficiencies listed.

There are four major tasks involved in developing a comprehensive and usable Gap Analysis: (1) developing a list of the most likely planning scenarios needed, along with estimates of the number of casualties anticipated for each scenario; (2) the development of requirements – i.e., the personnel and material resources needed to cope with each planning scenario if and when it becomes a reality; (3) current resources and capabilities; and (4) the gap in unmet requirements that results – in other words, the difference between the resources on hand and those still needed to cope with each planning scenario. Following is a brief discussion of how the various components of the complete Gap Analysis process are determined.

**The Planning Scenarios:** The goal here is to determine: (a) the types of emergencies most likely to occur within a given jurisdiction; and (b) realistic estimates of the number of casualties (i.e., live patients) likely to be generated by each planning scenario. To make these determinations, healthcare planners should consult first with the jurisdiction’s emergency-management agency (EMA) – the director of which usually would be

responsible for carrying out hazard vulnerability assessments (HVAs) for the entire community. Using the HVAs already developed, healthcare planners could compile a number of planning scenarios that the jurisdiction might reasonably be expected to face in the future.

*A very large number of disaster scenarios are possible, but the Gap-Analysis probably should be based only on a few – the top three, perhaps*

Of course, a very large number of disaster scenarios are *possible*, but the Gap-Analysis probably should be based only on a few – the top three scenarios, perhaps, identified from the community HVA carried out by the EMA. For each of those scenarios, the healthcare planner should then develop estimates of the probable number of patients that would be generated. The EMA also can help here, and may already have estimated not only the number of casualties and fatalities anticipated for each planning scenario but also the various categories of injuries (e.g., burns, blunt force trauma, and blast) most likely to occur.

Those estimates usually would be based at least in part on previous disasters – e.g., the bombing of London’s Underground (subway) system, the terrorist train bombings in Madrid, and/or the 1995 Sarin nerve-agent attack on the Tokyo subway

system. The local or state public health officer usually would be the most authoritative source in estimating the number of infected patients likely to be generated by events such as a new SARS outbreak or a pandemic influenza. The U.S. Department of Health and Human Services (HHS) and other federal public-health agencies – e.g., the Centers for Disease Control and Prevention (CDC) – also can provide reasonably accurate estimates of the numbers of persons likely to be infected in such incidents – and may, in addition, offer some timely advice on the likely percentages of victims who will require hospitalization.

### **The Development of Requirements:**

The goal in this step of the process is to fully and accurately identify all of the resources that would be needed to effectively treat the numbers and categories of patients likely to be generated by each of the disasters postulated in the community HVA. This is a daunting but not impossible task. Hospital requirements alone include but are not limited to beds, medical supplies, and equipment – e.g., ventilators, X-ray machines and other diagnostic equipment – and a broad spectrum of medicines and pharmaceuticals of all types. The requirements list also would include doctors, nurses, emergency medical services personnel, and other medical professionals. Ambulances and other transportation resources also are a permanent need; as are the continued availability of food, water, and electric power. In short, everything it takes to equip and operate a modern hospital or other medical facility should be on the requirements list.

Here, a caveat is necessary: The requirements or “needs” developed in a Gap Analysis should not be

influenced by the quantity or variety of resources the hospital already has on hand (and/or could readily purchase from its suppliers). In short, the requirements component of the analysis is not and should not be related to and/or based on the assets already available. It also should be recognized that, although completing the requirements development component of a Gap Analysis is not a difficult process, it usually *is* both tedious and time-consuming – which is perhaps why the development of requirements is often the most poorly defined component of the overall Gap Analysis process.

### Current Resources and Capabilities:

In this component of the process the entirety of the resources the healthcare organization has at its disposal are matched to (or measured against) the number and categories of patients it expects to treat. Many healthcare planners, it should be noted, believe that they must somehow obtain the additional resources needed to cope with a given scenario. However, that is not the case. The National Response Plan (NRP), and the proposed National

Response Framework (NRF), already have anticipated that *requirements will far exceed the local and state/territory resources available.*

The U.S. Department of Health and Human Services is the federal organization specifically responsible for public-health and medical-services sustainment support and, as such, already has been tasked to make up the difference between the city and state/territory resources and capabilities readily available and the total requirements and capabilities needed to medically manage the large-scale events postulated in the planning scenarios. It is imperative, therefore, that local and state/territorial resources and current capabilities be expressed both fully and accurately, and in as much detail as possible. Only then can the HHS framework (and the department's support organizations) properly plan, program, and budget for the entire array of facilities and resources needed, including a full complement of medical staff and the non-medical as well as medical goods and services required to support state/territory and

local governments during future mass-casualty disasters and other public-health emergencies.

### The Gap (or Unmet Requirements):

The gap developed for each planning scenario represents the difference between the resources and capabilities available and the total requirements identified. Not incidentally, the National Response Plan requires that local healthcare organizations pass on, to the local EMA, a complete list of *requirements exceeding available resources.* Those requirements that cannot be met at the local jurisdictional level must then be forwarded to the state/territory EMA. Finally, a list of the unmet state/territory requirements for resources and capabilities should be forwarded to the federal agency, HHS, primarily responsible for implementation – with the help of its various support agencies – of U.S. public-health and medical-services plans and policies.

Thanks to the somewhat complex but fairly well defined Gap Analysis process, HHS can analyze, plan, program, budget for, procure, and pre-position the additional resources and capabilities needed by lower jurisdictions to cope with major crises. The bottom line is that cooperation, teamwork, and advance planning are needed at all levels of government to sustain and fortify U.S. public-health agencies – and the nation's private healthcare industry – to prepare for future emergencies and disasters requiring federal support.

*James M. Rush has over 26 years of healthcare administration and community emergency-management experience in the U.S. armed forces, the U.S. public-health community, and the nation's civilian healthcare industry. He recently served as the Region III Project Officer for the National Bioterrorism Hospital Preparedness Program, which is dedicated to helping healthcare organizations prepare for "All Hazards" events and incidents. Rush is author of, among other published works, the "Disaster Preparedness Manual for Healthcare Materials Management Professionals."*

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# Hospital Emergency Management: The Anatomy of Growth

By Theodore Tully, Health Systems



For more than a century, the “emergency manager” of a U.S. hospital or any of the nation’s other healthcare facilities was seldom if ever identified by that specific job title. The reason was simple: Almost all of the nation’s hospitals usually planned – and developed their response capabilities – for a one-time disaster that would result in the unexpected delivery of one patient (or sometimes several) to that hospital – more specifically, to the hospital’s Emergency Department. For that reason alone it is not surprising that the person or persons charged with emergency (or disaster) planning for hospitals held more general job titles such as director of emergency medicine, or emergency department nurse manager, or security director, or the director of facilities management.

Some of the nation’s more forward-looking hospitals, though, created the role of emergency manager after the 11 September 2001 terrorist attacks. To date, however, most of the nation’s healthcare facilities have not yet made any major changes to their emergency-management plans, nor have they assigned the “emergency manager” title to one of their senior healthcare officials – who in most if not all facilities would be responsible for emergency planning as well as emergency management.

On 11 September 2001 itself many if not all hospitals throughout the country, not knowing if and where additional attacks might take place, had those officials responsible for their emergency planning immediately activate some level of the hospital’s emergency plan. The typical account of what happened that day would often start with a statement that “My CEO called me and said to meet him in his office immediately.” In the weeks immediately after 9/11, hospitals reacted to the terrorist attacks

more carefully, more thoughtfully, and in much greater detail – and also were making a major effort to find the additional funds needed to prepare for the next possible terrorist incident that might eventually affect their institution.

## ***A More Than Tenfold Increase in Three Years***

In a survey (*Emergency Preparedness Funding*) of New York City metropolitan area hospitals carried out last year by the Greater New York Hospital Association (GNYHA), the hospitals participating in the survey estimated that they had spent, on average, \$126,215 for emergency preparedness in 2000. By 2003 that bottom-line total had increased to \$1,355,744 on average, but only a very small percentage of that sum came from federal grant funding – *which means that the average hospital participating in the survey had increased its emergency-preparedness funding more than tenfold in only three years.* Whether the much larger financial resources being allocated for emergency preparedness are now sufficient has yet to be determined, but it is obvious that the city’s hospitals are today much more prepared to handle mass-casualty incidents than they had been prior to the 9/11 attacks.

Given the major financial problems facing most of the nation’s healthcare facilities today, one can easily understand how difficult it is for hospital administrators to allocate additional resources for a major contingency situation that: (a) is not a “profit center” per se; (b) is minimally paid for through federal grants; and (c) quite possibly may never be needed. Over the past few years most U.S. hospitals, with the possible exception of very large healthcare systems or trauma centers, tapped existing personnel to supervise the emergency planning required for the management of mass-casualty incidents and events. With the list of

needs and requirements still increasing annually, though, many – probably most – of these hospital support people have felt overwhelmed by the planning and emergency-management tasks that have been added to their previous workloads.

The Joint Commission (JC – the organization responsible for the accreditation of U.S. hospitals and other healthcare facilities\*), recently strengthened and increased the emergency-planning standards required for accreditation and, according to current plans, will publish even more rigorous requirements sometime next year.

The commission’s actions, although both necessary and understandable, are forcing the nation’s hospitals to ask themselves who, specifically, should be their new emergency managers, what his or her duties will be, and how much administrative and *budgetary* authority they will be given. The answers to those questions will be a reasonably accurate reflection of how seriously a task emergency management is considered to be by a specific hospital or other healthcare organization.

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*\*The commission, founded in 1951 as the Joint Commission on Accreditation of Hospitals (JCAH), changed its name to JCAHO (Joint Commission on Accreditation of Healthcare Organizations) in 1987, but is now usually referred to simply as the Joint Commission. For more information on the Joint Commission see the commission’s website: [www.jointcommission.com](http://www.jointcommission.com)*

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*Theodore Tully has been director of Trauma and Emergency Services at the Westchester Medical Center (WMC) in Westchester County, N.Y., since 1994. Prior to assuming that post he served as a police paramedic/detective and as the Westchester County EMS (emergency medical services) coordinator. He also helped create and administer the WMC Regional Resource Center, which is responsible for coordinating the emergency plans of 32 hospitals in the greater Westchester County area.*

## New York, Louisiana, Arkansas, and Arizona

By Adam McLaughlin, State Homeland News



### New York **NYC Fire Department Starts Work on High- Rise Fire Simulator**

The New York City Fire Department has started the development of a simulator that will help firefighter trainees prepare to face a particularly dangerous type of blaze – a high-rise fire.

The four-story, 4,000-square-foot training structure, which will be built atop an existing building, will be fitted with a dry standpipe system, mock elevators and stairways, and a mock fire command station as well as realistic layouts of residential, office, and commercial spaces.

The training area will be able to simulate both a fire and a “flashover” – i.e., the moment when everything combustible in a space goes up in flames. There also will be video hookups on each floor for teaching purposes. The huge simulator is scheduled to be completed next year.

At the groundbreaking ceremony, Mayor Michael Bloomberg said the \$4.5 million simulator “will help train our members for one of the most notoriously complex parts of the job.”

Since 2004, city officials said, more than \$60 million has been dedicated to improving the NYC Fire Academy facilities. Last year, two of the city’s firefighters died in an August blaze at the former Deutsche Bank building, a condemned 41-story skyscraper. In the 2001 terrorist attacks, 343 firefighters were killed in the collapse of the 110-story twin towers of the World Trade Center.

At the former Deutsche Bank building, a new fire-suppression system will be able to detect a breach

in the standpipe, officials said last Wednesday. The standpipe, which supplies water to fire hoses, was broken when the fire broke out.

### Louisiana **State National Guard Will Continue Patrols in New Orleans**

Louisiana will pay \$10.5 million to keep Louisiana National Guard troops in New Orleans through June to help fight crime, under spending plans approved in late January by state lawmakers.

The earmark for the 360 Guardsmen patrolling New Orleans neighborhoods boosts total state spending on Guard and state police patrols in the Crescent City to more than \$56 million since Hurricane Katrina. Today, only the Guardsmen remain on duty; the final state police withdrawal came in late 2007.

The funding approved last month by the Joint Legislative Committee on the Budget covers the operational expenses incurred from the start of Governor Bobby Jindal’s term earlier this month through the end of the budget year on 30 June. The money, taken from a state emergency-response fund, covers salaries, hotel expenses, equipment, and various other costs.

The state’s lawmakers also agreed to spend \$662,000 to set up tents and a temporary clinic in New Orleans during Carnival to provide medical care. Many New Orleans hospitals have been overextended since Katrina struck in August 2005. “We need to make sure that the people who are visiting the city are attended to,” said State Rep. Karen Carter Peterson (D-New Orleans).

The balance in the \$150 million set-aside fund for state emergencies is

shrinking rapidly, and there is now less than \$41 million remaining. Lawmakers and then-Governor Kathleen Blanco created the fund in 2006 to prepare for hurricane evacuations and other emergencies. The dollars already spent have been used for the purchase of blankets and cots for hurricane shelters, office equipment, miscellaneous supplies for pet shelters, pandemic flu preparations, a new phone system for the governor’s homeland-security office, a backup data center at Louisiana Tech University in Ruston, and upgraded communications equipment for first responders throughout the state.

### Arkansas **Tornado Victims Will Use Trailers as Temporary Housing**

Some of the thousands of trailers purchased by the Federal Emergency Management Agency (FEMA) in 2005 after hurricanes tore through the Gulf Coast may finally be put to good use – to help victims of last week’s tornadoes, Arkansas officials said on 13 February.

The 7,200 trailers stored at the Hope airport will “definitely” be used in Arkansas as temporary housing for victims of the tornadoes, said David Maxwell, head of the Arkansas Department of Emergency Management. That decision came in response to requests by state officials and members of Arkansas’ congressional delegation, many of whom – frustrated by the slow response to hurricanes Katrina and Rita – had criticized the inadequate use (mostly non-use) of trailers at that time as a sign of federal ineptitude.

Maxwell said that his office told FEMA immediately after last week’s tornadoes struck that the victims needed shelter and would be able to use some of the trailers. FEMA Administrator R. David

Paulison said, while on a tour of some of the most heavily damaged areas, that the agency would prefer to house storm victims in rental properties, but he acknowledged that could be difficult to do in rural communities.

“Knowing rural Arkansas and the areas that were hit, there is not a lot of rental property [available],” Maxwell commented. “Then you are stuck with mobile homes.” He said that, rather than FEMA simply agreeing on a predetermined number of trailers, the number released would depend at least in part on the number of displaced victims who called FEMA and requested help. FEMA already has hired a contractor to prepare and, possibly, transport the trailers to those in need, he added.

After Katrina hit Louisiana and Mississippi in 2005, FEMA purchased 25,000 manufactured homes, which had been built at a cost estimated at more than \$850 million. Many of the trailers available at that time went unused, though, even though many of the hurricane victims were still homeless.

FEMA has about 75,000 trailers and mobile homes pre-positioned in various locations across the country. However, Congress ordered FEMA last year to stop selling or donating the property after discovering that a number of the trailers were experiencing what were called “formaldehyde problems.” In November, FEMA spokesman James McIntyre said that the agency has determined that most of its mobile homes are now safe to use – but he also said that the agency was still in the process of testing the travel trailers stored at the Hope airport.

Twelve people were killed along the 120-mile path devastated by one Arkansas tornado on 5 February. Nationally, 59 people died in the storms that lashed across five states.

### ***Arizona Double-Barreled Criticism For New DHS Fencing Plans***

The U.S. Department of Homeland Security (DHS) plans to add 11 miles of new fencing this year on the border east of Nogales between Arizona and Mexico, and four miles of new fencing along the Colorado River; the new fencing will be a combination of pedestrian fences, vehicle barriers, and what are generically described as access-road improvements.

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However, this new border-security effort is receiving criticism not only from those who oppose the new fencing plan but also from some supporters of the initiative. Environmentalists say that DHS is threatening endangered animals by ignoring environmental laws to build barriers across the animals’ habitats. “I am really now very concerned about an ecological disaster ... [that could be precipitated] by blocking off this border,” said Kim Vacariu, western director of The Wildlands Project.

Pro-fence supporters, on the other hand, accuse DHS of backing off its obligations not only by not building enough pedestrian fencing but also by not “double-layering” the fencing that is built. These advocates also say that

much more fencing is critically needed in a state that remains the most active drug- and human-smuggling route along the entire U.S.-Mexican border.

Glenn Spencer, founder of American Border Patrol, has asserted, for example, that the federal government cares more about open borders and providing amnesty for illegal immigrants than it does about building the fences and curbing illegal immigration. “Where the smuggling is really serious, they [the federal government] are not building anything,” Spencer said. Federal officials pointed out, though, that Arizona benefited significantly from a major effort carried out last year when almost all of the 74 miles of new fencing completed that year went up in Arizona.

However, the federal fencing strategy varies from one part of the border to another, and usually is based on local conditions. “What makes sense here might not work there,” said U.S. CBP (Customs and Border Patrol) spokesman Lloyd Easterling. “We are interested in putting in the right mix, based on terrain, location, and maintenance needs,” he said.

Border Patrol officials said that the agency has no immediate plans for installing additional pedestrian fencing in Arizona, but might add some additional vehicle barricades, access-road improvements, and networks of cameras and sensors. Current CBP plans call for 85 new miles of various types of barriers in Texas, 59 miles in California, and 25 miles in New Mexico as part of an effort to better secure 670 miles of the 1,950-mile international border by the end of this year.

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