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Active Shooter Planning for Health Care Facilities

Introduction

Our Nation's health care facilities (HCFs) are entrusted with providing expert medical care in safe and secure environments for patients, staff, and visitors. HCFs include hospitals, health clinics, hospices, long-term care facilities, academic medical centers, group medical care facilities, and physicians' and other health care providers' offices. HCFs are faced with planning for emergencies of all kinds, ranging from active shooters, hostage situations, and other similar security challenges, as well as threats from fires, tornadoes, floods, hurricanes, earthquakes, and pandemics of infectious diseases. Many of these emergencies occur with little to no warning; therefore, it is critical for HCFs to plan in advance to help ensure the safety, security, and general welfare of all members of the health care community.

This document is primarily designed to encourage facilities to consider how to better prepare for an active shooter[1] incident. Though hospitals and many other HCFs have emergency operations plans (EOPs), this document provides emergency planners, disaster committees, executive leadership, and others involved in emergency operations planning with detailed discussions of unique issues faced in an HCF. This document also includes discussions on related topics, including information sharing, psychological first aid (PFA), and law enforcement/security.

EOPs for HCFs should be living documents that are routinely reviewed and consider all types of hazards, including the possibility of an active shooter or terrorist incident. As law enforcement continues to draw lessons learned from actual emergencies, HCFs should incorporate those lessons learned into existing EOPs or in newly created EOPs.

A whole community approach to HCFs includes staff, patients, and visitors. Likewise, the whole HCF community includes individuals with access and functional needs. Examples of these populations include children, older adults, pregnant women, individuals with disabilities, individuals who live in institutional settings, individuals from diverse cultures, individuals who have limited English proficiency or are non-English speaking, individuals who are transportation disadvantaged, individuals experiencing homelessness, individuals who have chronic medical conditions, and individuals who have pharmacological dependency.

Background

National preparedness efforts, including planning, are based on Presidential Policy Directive (PPD) 8: National Preparedness, which was signed by the President in March 2011. This directive represents an evolution in our collective understanding of national preparedness based on lessons learned from natural disasters, terrorist acts, and active shooter and other violent incidents.

PPD-8 defines preparedness around five mission areas: Prevention, Protection, Mitigation, Response, and Recovery. These concepts are also applicable to HCF planning for an active shooter incident or other event, and the below definitions have been modified from PPD-8 for the purposes of this guide:

[1] Active shooter incidents are defined as those where an individual is "actively engaged in killing or attempting to kill people in a confined and populated area." "Active Shooter: How to Respond." U.S. Department of Homeland Security. 2013.

- **Prevention**,[2] for the purposes of this guide, means the capabilities necessary to avoid, deter, or stop an imminent threat. Prevention is the action HCFs take to keep a threatened or actual incident from occurring.
- **Protection** means the capabilities to secure HCFs against acts of terrorism and man-made or natural disasters. Protection focuses on ongoing actions that protect patients, staff, visitors, networks, and property from a threat or hazard.
- **Mitigation** means the capabilities necessary to eliminate or reduce the loss of life and property damage by lessening the impact of an event or emergency. In this document, mitigation also means reducing the likelihood that threats and hazards will happen.
- **Response** means the capabilities necessary to stabilize an emergency once it has already happened; restore and establish a safe and secure environment; save lives and prevent the destruction of property; and facilitate the transition to recovery.
- **Recovery** means the capabilities necessary to assist HCFs affected by an event or emergency in restoring the treatment/therapeutic environment as soon as possible.

Emergency management officials and emergency responders engaging with HCFs are familiar with this terminology. These mission areas generally align with the three temporal frameworks (time frames) associated with an incident: pre-incident, incident, and post-incident environment. Most of the prevention, protection, and mitigation activities generally occur before or are modifications after an incident, although these three mission areas do have ongoing activities that can occur throughout an incident. Injury prevention can and should occur in all three temporal matrices. Response activities occur during an incident, while Recovery activities can begin during an incident and occur after an incident. To help avoid confusion over terms and allow for ease of reference, this guide uses "before," "during," and "after."

Planning teams at HCFs responsible for developing and revising an EOP should use the concepts and principles of the National Incident Management System (NIMS) to incorporate planning efforts into the EOP that are related to active shooter incidents and other hostile threats. One component of NIMS is the Incident Command System (ICS), which provides a standardized approach for incident management, regardless of cause, size, location, or complexity of the event. By using the ICS during an incident, HCFs will be able to work more effectively with the first responders in their communities.[3]

The departments[4] issuing this guidance do so primarily to encourage an open and frank discussion of these complex and sometimes difficult topics. Examples of good practices and matters to consider have been included for planning and implementation purposes; however, HCF emergency managers—with the support of the HCF leadership and in conjunction with

[2] In the broader PPD-8 construct, the term *prevention* refers to those capabilities necessary to avoid, prevent, or stop a threatened or actual act of terrorism. The term *prevention* also refers to preventing imminent threats.

[3] For more information on the National Incident Management System and the Incident Command System, please see http://www.fema.gov/national-incident-management-system. For information on IS-200.HCA – Applying ICS to Healthcare Organizations, please see http://training.fema.gov/EMIWeb/IS/courseOverview.aspx?code=IS-200.HCa. All Web sites referenced in this document were active at the time of publication.

[4] Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response; Department of Justice, Federal Bureau of Investigation; and Department of Homeland Security, Federal Emergency Management Agency.

local emergency managers and responders—must consider what is most appropriate for that facility and its staff, patients, and visitors. The guidance does not create any requirements beyond those included in applicable laws and regulations, or create any additional rights for any person, entity, or organization. Additionally, planning teams should consider state and local and tribal laws and regulations. The information in this document is meant to highlight issues and provide examples that may be helpful. The inclusion of certain references does not imply any endorsement of any documents, products, or approaches. Other resources may be equally helpful and should be considered in creating or revising existing EOPs.

Challenges

HCFs face numerous challenges in emergency planning in terms of geography, environment, governance, and the population served. The facilities themselves can be large or small; urban, suburban, and rural; temporary, mobile, or permanent; and may be public, academic, or private institutions. Facilities are both residential and non-residential (outpatient), though many operate around-the-clock. These facilities, and the individual providers, are often subject to a wide array of legal, regulatory, and other credentialing requirements. While each of these institutions shares a common focus on providing and improving patient care, each has a distinct operational environment and, accordingly, distinct challenges in emergency planning. To address the challenges these characteristics pose, HCFs can take steps to plan for potential emergencies by working with local government and community partners to develop an HCF EOP. The following are some examples of potential challenges to consider.

Complex, Multifaceted Enterprises

HCFs are complex, multifaceted enterprises. In addition to their primary health care role, they often serve as community centers and emergency care facilities, as well as residential treatment complexes. They sometimes operate emergency ambulance and patient transportation systems. They often are open to the public and integrated into the surrounding community, with visitors regularly receiving medical care at various locations throughout the facility. Security personnel may or may not be present, offering different levels of protection.

HCFs often include multiple buildings and structures in addition to the area where patients are seen or housed. These may include parking garages, medical office buildings, and other locations, which expand the security concerns for the HCF if an armed person or persons gains access.

Operational Demands

With an increasing volume of patients and a reduction in emergency departments and acute care beds, HCFs in the United States are operating at or near capacity on a daily basis.[5] With ambulances on diversion and full waiting rooms, hospitals have limited capacity to manage the impact of a mass casualty event or public health emergency. In a mass casualty incident, a HCF

[5] Pitts, Stephen R., et. al. "A Cross-sectional Study of Emergency Department Boarding Practices in the U.S." Academic Emergency Medicine, Vol. 21. Issue 5, May 2014.

may need to provide a level of care beyond its normal responsibilities and its capabilities. This can stress resources, increase vulnerabilities and needs, and impact critical missions.

Potential Targets

Many HCFs are repositories for critical research, sensitive information, radioactive materials, and other dangerous pharmaceuticals and narcotics. They often sponsor activities and events that increase their vulnerability. It is common for major research institutions to employ prominent people and conduct research in areas such as nuclear medicine, biochemistry, and controversial general medicine procedures and practices such as stem cell and animal research. Research conducted at HCFs may attract the interest of groups or individuals with opposing ideological beliefs to the HCF. Moreover, many HCFs have radiological and nuclear materials available for research and patient treatment. Safeguarding these materials from terrorists and other criminal threats is a matter of national importance.

Highly Varied and Widely Dispersed

HCF governance is highly varied and often widely dispersed. Many institutions have decentralized organizational structures and departments with differing processes and decision-making responsibilities, with variations not only in the clinical care provided, but also in their organizational structure, operations, and administration. HCFs may operate emergency ambulance and transport systems, serve as community centers, and operate residential facilities. They are also governed by an array of governmental and nongovernmental authorities that oversee accreditation, licensing and specialty certification, patient care, research, accessibility, reimbursement, and daily operations.

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Vulnerabilities

In addition to housing patients, including individuals with access and functional needs, all HCFs house sensitive patient information, and many HCFs possess essential research infrastructure. These activities may place them at greater vulnerability for and from an event. Any disruption may lead to injury and illness in the patient population, damage of critical research efforts, or the exposure of sensitive, protected patient information.

Workforce

The workforce at any given HCF may be a hybrid of community providers with staff privileges and facility-based employees. The 24/7 nature of many HCFs leads to physicians, nurses, health care administrators, allied health professionals, and volunteers often working unconventional hours, with rotating and irregular shifts. Providers receive their training from a wide range of sources, leading to varied levels of resilience. These factors make consistent and uniform emergency preparations challenging.

Health care providers dedicate their lives to taking care of others. How they respond during an active shooter incident will be an intensely personal choice that may be influenced by moral, ethical, religious, professional, or other views.

Resource Constraints

In the current health care environment, leaders must choose between competing needs. Emergency preparedness activities have to compete with other, day-to-day activities like quality improvement, patient safety, and general facility and financial management including staff salaries, procurement of needs, and infrastructure/growth design/development.

Dynamic

When an emergency occurs within the facility, HCF personnel should react immediately, providing first aid and triage safely in secure areas, notifying response partners, and providing direction through actionable information in accessible formats before first responders arrive. HCF officials, including pre-designated incident commanders, should engage in a coordinated way to work with partners across the institution. They should also coordinate with the community partners, including first responders (law enforcement officers, fire department officials, and emergency medical services [EMS] personnel), emergency managers, and public health and mental health practitioners. Lessons learned from actual emergencies highlight the importance of preparing HCF staff including administration, security, and incident commanders; government officials; and first responders to act quickly, with enhanced safety, and in a coordinated manner. By having plans in place to keep patients, staff, and visitors safe, HCFs play a key role in taking preventive and protective measures to prevent an emergency from occurring or reduce the impact of an incident when one does occur.

Active Shooter Incidents

Active shooter incidents are defined as those where an individual is "actively engaged in killing or attempting to kill people in a confined and populated area."[6] Law enforcement generally applies this definition to situations where the individual is armed with at least one gun and has come to the area, with the intent to kill people, not to commit another crime. Sometimes the incident occurs inside a building, sometimes outside. In each instance, law enforcement responds to the scene following a set of protocols that require them to find, end the threat, and ensure that everyone in the affected area has been accounted for and is safe. Though the majority of recent active shooter incidents have occurred in business and school environments, HCFs also face the threat of an active shooter.

Other gun-related incidents that may occur in a health care environment are not defined as active shooter incidents because they do not meet this definition. However, these should also be accounted for in plans. These incidents may involve a single shot fired, an accidental discharge of a weapon, or incidents that are not ongoing. Because these incidents rarely involve an ongoing threat to those present at the HCF, the way civilians and law enforcement respond will be different.

During an active shooter incident, the natural human reaction, even for those who are highly trained, is to be startled, feel fear and anxiety, and even experience initial disbelief and denial.

[6] "Active Shooter: How to Respond." U.S. Department of Homeland Security. 2013.

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There may be noise from alarms, gunfire and explosions, and people shouting and screaming. Training provides the means to regain composure, recall at least some of what has been learned, and commit to action.

Training for personnel can focus on the easy-to-remember mantra of “Run, Hide, Fight.” As HCFs train and discuss these options, they should be viewed on a continuum. Everyone should be trained first to run away from the shooter, if possible, encouraging others to follow. If that is not possible, they should seek a secure place to hide and deny the shooter access. As a last resort, each person must consider whether he or she can and will fight to survive, incapacitate the shooter, and protect others from harm. Though this may seem extreme, in a study of 51 active shooter incidents that ended before law enforcement arrived, the potential victims stopped the attacker themselves in 17 instances. In 14 of those cases, they physically subdued the attacker.[7]

Because of the ongoing nature of an active shooter incident, however, those working in an HCF are faced with numerous planning and response challenges.

Health care professionals may be faced with the decision about the safety of patients and visitors in their care who may not be able to evacuate due to age, injury, illness, disability or because of an ongoing medical procedure. Understandably, this is a sensitive topic. As appropriate for the HCF, it may be valuable to schedule times for open conversations with employees to explore this topic. This guide provides points for discussion. Though some health care staff may find the conversation uncomfortable, they also may find it reassuring to know that the HCF is thinking about how best to deal with this situation. There is no single answer for what to do, but a survival mindset and open and honest discussion can help increase the odds of survival.

The ideal situation is to prevent an active shooter incident altogether. This section will discuss ways to strengthen your facility’s planning and prevention efforts with regard to active shooters. It will address what civilians should expect and do if a shooting occurs and what to expect when law enforcement responds to an active shooter incident. Finally, it will provide information on assisting victims.

Each person carries a three-fold responsibility.

First: Learn signs of a potentially volatile situation and ways to prevent an incident.

Second: Learn steps to increase survival of self and others in an active shooter incident.

Third: Be prepared to work with law enforcement during the response.

Planning for an Active Shooter Incident

As with any threat or hazard that is included in an HCF EOP, the planning team should establish goals, objectives, and courses of action for an active shooter annex. These plans will be impacted by the assessments conducted at the outset of the planning process and updated as ongoing assessments occur. Create the plan with input from internal and external stakeholders. External stakeholders include local police, EMS, emergency management, fire, and people with disabilities. Internal stakeholders include executive leadership, clinical care providers, security, facility engineering, human resources, ethicists, chaplains, and risk managers.

[7] Blair, J. Pete, Martaindale, M. Hunter and Terry Nichols. "Active Shooter Events 2000-2102". FBI Law Enforcement Bulletin, January 2014.

An effective plan includes:

- Proactive steps, including training, that can be taken by employees to identify individuals who may be on a trajectory to commit a violent act.
- A preferred method for reporting active shooter incidents, including informing all those at the HCF or who may be entering the HCF.
- An evacuation policy and procedure.
- Emergency escape procedures and route assignments (e.g., floor plans, safe areas).
- Lockdown procedures for individual units, offices, and buildings.
- Integration with the facility incident commander and the external incident commander.
- Information concerning local area emergency response agencies and hospitals (e.g., name, telephone number, and distance from the location), including internal phone numbers and contacts.

As courses of action are developed, the planning team should consider a number of issues, including:

- How to evacuate, shelter in place, or "lock down" patients, visitors, and staff.
    - Personnel involved in planning should pay close attention to accessibility requirements when advising on sheltering sites and evacuation routes. Individuals with access and functional needs, such as individuals with disabilities or individuals with limited English proficiency, may face a variety of challenges in evacuating. People with a mobility disability may need assistance leaving a building without a working elevator and may need accessible modes of transportation to move to an evacuation point nearby the HCF. People needing accessible communications, such as individuals who are blind or who have low vision or individuals who have limited English proficiency or who are non-English speaking may not be able to independently use traditional orientation and navigation methods such as exit or evacuation signs. An individual who is deaf or who has cognitive or intellectual disability may be trapped somewhere unable to communicate if they cannot hear or speak to responders. Children require adult supervision and require support to evacuate safely and avoid becoming lost or separated. Procedures should be in place to ensure that people with access and functional needs can evacuate the physical area in a variety of conditions and accommodation must be provided for those who require assistance.
- How and where to evacuate when the primary evacuation routes are unusable.
    - For example, include discussions about not moving to a nearby evacuation location designated for fire drills if a shooter might still be in the area.
- How to select effective shelter-in-place locations.
    - Optimal locations have ballistic protection known as "cover," which includes thick walls made of steel, cinder block, or brick and mortar; solid doors with locks; and areas with minimal glass and interior windows. These areas can be

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stocked with accessible first aid and emergency kits designed for hemorrhage control, communication devices, and telephones and/or duress alarms.

  - Designated "shelter in place" locations are often designed for natural hazards (e.g., earthquakes, tornadoes, etc.) and so may not be ideal for active shooter incidents. See below for a discussion of safe rooms.

- Train staff in Psychological First Aid (PFA).
  - PFA is an evidence-informed, modular approach used by mental health and disaster response workers to help individuals of all ages in the immediate aftermath of disaster and terrorism. PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping. PFA does not assume that all survivors will develop mental health problems or long-term difficulties in recovery. Instead, it is based on an understanding that disaster survivors and others affected by such events will experience a broad range of early reactions (e.g., physical, psychological, behavioral, spiritual). Some of these reactions will cause enough distress to interfere with adaptive coping, and recovery may be helped by support from compassionate and caring disaster responders and trained community members.

Additional planning considerations include creating a facility security plan and practicing its practicability. A facility security plan includes:

- Understanding indications of workplace violence and taking immediate remedial actions accordingly.
  - Oftentimes, perpetrators of crime display visible pre-event indicators. Even small bits of information promptly reported may be pieced together to prevent a violent act. (See the Threat Assessment Team section of this document.)
- Requiring employees, medical staff, students, volunteers, and contractors to display an authorized identification badge properly.
- Creating a culture of vigilance and safety by empowering employees and staff to report unusual, dangerous, or suspicious activity.
- Ensuring locked doors remain closed and locked.
- Changing codes on doors with keypad access at specified intervals; and controlling dissemination of codes.
- Empowering employees who come in contact with individuals who seem lost or are obviously not familiar with their surroundings to be helpful and ask if they can be of assistance.
- Providing safe rooms in health care settings.
  - Some facilities have opted to construct safe rooms. Such rooms are designated spaces where staff, patients, and even visitors can retreat to in the event of an immediate threat of danger. A designated safe room should be equipped with a duress button, telephone, reinforced, locking doors with peep-holes installed, and an external lock with key access. Safe rooms must provide physical and communication accessibility for people with disabilities.

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- Explaining how communications occur including when there is an active shooter on site, the ongoing status of the incident, and when it is "all clear."
    - This could be done through the use of familiar terms, sounds, lights, and electronic communications, such as text messages or e-mails. Generally, plain language communications, not coded, should be used in conjunction with any coded light and sound systems to maximize message delivery. If the use of coded language is necessary, beyond merely training staff, extra care should be given to how best to communicate the presence of an active shooter to others at risk.[8] How to communicate with those who have language barriers or need other accommodations, such as visual signals or alarms to advise deaf patients, staff, and visitors about what is occurring, should be included in the courses of action. How to communicate with areas of the facility that have no public address or communications system should also be addressed. HCF-wide "reverse 911-style" text messages sent to pre-determined group distribution lists can be very helpful in this regard. Planners should make sure this protocol is readily available and understood by those who may be responsible for sending out or broadcasting an all-HCF announcement. To reduce the time between recognition of a threat and transmitting an alert, a variety of people need to be able to authorize and execute these broadcasts. Rapid notification of a threat can save lives by keeping people out of harm's way.
- Developing an emergency notification system.
    - The emergency notification system can alert various parties of an emergency including:
        - Individuals at other locations on the premises;
        - Staff or visitors with access and functional needs, including those with limited English proficiency;
        - Local emergency responders; and
        - Other local area hospitals.

The notification system can also provide an indication for how patients, visitors, and staff will know when HCF grounds are safe.

While there is a sense in the popular culture that a clear warning may induce panic, research shows that people do not panic when given clear and informative warnings.[9] Research also shows that people want to have accurate information and clear instructions on how to protect themselves in the emergency. For many HCFs, not all members of the HCF community will understand a code system; therefore, plain language warnings and clear instructions should be

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[8] Many HCFs use color-coded alert systems that already include weapons/active shooter alerts (see http://www.hasc.org/hospital-emergency-codes). Planners should develop hybrid protocols which also incorporate plain language alerts to ensure the widest notification in the affected areas.

[9] Mileti, Dennis S. and John H. Sorensen. "Communication of Emergency Public Warnings: A Social Science Perspective and State-of-the-Art Assessment." Oak Ridge, TN: Oak Ridge National Laboratory, U.S. Department of Energy. 1990.

given. As appropriate to the community, clear, consistent, accessible, and culturally and linguistically appropriate methods should be used to effectively relay information.

The planning team may want to include functions in an active shooter functional annex (i.e., an addendum to the EOP) that are also addressed in other functional annexes. For example, evacuation will be different during an active shooter incident than it would be for a fire.

Finally, the planning team should incorporate training opportunities and take into consideration the more detailed discussion later in this document about civilian response and law enforcement response protocols in documenting response procedures.

Who is the Active Shooter?

No profile exists for an active shooter; however, research indicates there may be signs or indicators. HCF employees should learn the signs of a potentially volatile situation that could develop into an active shooter incident. Each employee should be empowered to proactively seek ways to prevent an incident with internal resources or additional external assistance.

By highlighting common pre-attack behaviors displayed by past offenders, researchers have sought to enhance the detection and prevention of tragic attacks of violence, including active shooting situations. Several agencies within the Federal Government continue to explore incidents of targeted violence in the effort to identify these potential "warning signs." Lessons learned from incidents during the last decade have aided first responders in better understanding how these incidents occur and how to prevent them.

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Though current studies are underway, past research on pre-attack behavior in areas such as violence at workplaces and institutions of higher education may help HCF employees in identifying behaviors of concern. For example, in 2002, the Federal Bureau of Investigation (FBI) published a monograph on workplace violence, including problematic behaviors of concern that may telegraph violent ideations and plans.[10] In 2010, the U.S. Secret Service, U.S. Department of Education, and the FBI collaborated to produce the report *Campus Attacks: Targeted Violence Affecting Institutions of Higher Education*, which examined lethal or attempted lethal attacks at U.S. universities and colleges from 1900 to 2008.[11] The report featured several key observations related to pre-attack behaviors, including the following:

- Concerning behaviors were observed by friends, family, associates, professors, or law enforcement in 31 percent of the cases. These behaviors included, but were not limited to, paranoid ideas, delusional statements, changes in personality or performance, disciplinary problems on site, depressed mood, suicidal ideation, non-specific threats of violence, increased isolation, "odd" or "bizarre" behavior, and interest in or acquisition of weapons.

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[10] *Workplace Violence: Issues in Response*. U.S. Department of Justice, FBI Academy. 2002.

[11] *Campus Attacks: Targeted Violence Affecting Institutions of Higher Education*. Joint publication of U.S. Secret Service, U.S. Department of Education, and Federal Bureau of Investigation. 2010.

- In only 13 percent of the cases did subjects make verbal and/or written threats to cause harm to the target. These threats were both veiled and direct and were conveyed to the target or to a third party about the target.
- In 19 percent of the cases, stalking or harassing behavior was reported prior to the attack. These behaviors occurred within the context of a current or former romantic relationship or in academic and other non-romantic settings. They took on various forms, including written communications (conventional and electronic), telephone contact, and harassment of the target and/or the target's friends and/or family. Subjects also followed or visited the target(s) or their families or damaged property belonging to the target(s) or their families prior to the attack.
- In only 10 percent of the cases did the subject engage in physically aggressive acts toward the targets. These behaviors took the form of physical assaults, menacing actions with weapons, or repeated physical violence to intimate partners.

Specialized units in the Federal Government, such as the FBI's Behavioral Analysis Unit, continue to support behaviorally-based operational assessments of persons of concern in a variety of settings (e.g., schools, workplaces, places of worship) who appear be on a trajectory toward a violent act. A review of current research, threat assessment literature, and active shooting incidents, combined with the extensive case experience of the Behavioral Analysis Unit, suggests that there are observable pre-attack behaviors that, if recognized, could lead to the disruption of a planned attack.[12] While checklists of various warning signs are often of limited use in isolation, the FBI has identified some behavioral indicators that should prompt further exploration and attention from law enforcement and/or HCF safety stakeholders. These behaviors often include:

- Development of a personal grievance.
- Contextually inappropriate and recent acquisitions of multiple weapons.
- Contextually inappropriate and recent escalation in target practice and weapons training.
- Contextually inappropriate and recent interest in explosives.
- Contextually inappropriate and intense interest or fascination with previous shootings or mass attacks.
- Experience of a significant real or perceived personal loss in the weeks and/or months leading up to the attack, such as a death, breakup, divorce or loss of a job.

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[12] Calhoun, Frederick and Stephen Weston. *Contemporary Threat Management: A Practical Guide for Identifying, Assessing, and Managing Individuals of Violent Intent*. San Diego, CA: Specialized Training Services. 2003.

Deisinger, Gene, et al. *The Handbook for Campus Threat Assessment and Management Teams*. Stoneham, MA: Applied Risk Management. 2008.

Fein, Robert, et al. *Threat Assessment: An Approach to Prevent Targeted Violence*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. 1995.

Monahan, John, et al. *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence*. New York, NY: Oxford University Press. 2001.

Vossekuil, Bryan, et al. *The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States*. Washington D.C.: U.S. Department of Education and U.S. Secret Service, 2004.

Few offenders had previous arrests for violent crimes.

Threat Assessment Team

As described in the previous section, research shows that perpetrators of targeted acts of violence engage in both covert and overt behaviors preceding their attacks. They consider, plan, prepare, share, and, in some cases, move on to action.[13] One of the most useful tools an HCF can develop to identify, evaluate, and address these troubling signs is a multidisciplinary HCF Threat Assessment Team (TAT). A TAT with diverse representation often will operate more efficiently and effectively. TAT members should include HCF administrators, human resources, counselors, current employees, medical and mental health professionals, public safety, and law enforcement personnel.

The TAT serves as a central convening body that ensures that warning signs observed by multiple people are not considered isolated incidents and do not slip through the cracks as they actually may represent escalating behavior that is a serious concern. TATs are already an established protocol in most educational settings and have proven quite valuable. HCFs should keep in mind, however, the importance of relying on factual information (including observed behavior) and avoid unfair labeling or stereotyping to remain in compliance with civil rights, privacy, and other applicable Federal and state laws.

For the purposes of consistency and efficiency, a TAT should be developed and implemented in coordination with HCF policy and practice. In addition, individuals and groups within the HCF already working to identify staff needs can be a critical source of information on troubling behavior for a TAT.

The TAT reviews troubling or threatening behavior of current or former patients and family members, visitors, staff, or other persons brought to the attention of the TAT. The TAT contemplates a holistic assessment and management strategy that considers the many aspects of the potentially threatening person's life—familial, academic, residential, work, and social. More than focusing on warning signs or threats alone, the TAT assessment involves a unique overall analysis of changing and relevant behaviors. The TAT takes into consideration, as appropriate, information about behaviors, various kinds of communications, information that has not been substantiated, any threats made, security concerns, family issues, or relationship problems that might involve a troubled individual. The TAT also may identify any potential victims with whom the individual may interact. Once the TAT identifies an individual who may pose a threat, the team will identify a course of action for addressing the situation. The appropriate course of action—whether law enforcement intervention, counseling, or other actions—will depend on the specifics of the situation.

While TATs are not common in HCFs, they have been pushed to the forefront of concern, and mandated by some states, and at institutions of higher education following the 2007 shooting at Virginia Polytechnic Institute and State University (Virginia Tech) in Blacksburg, VA, where 32 individuals were killed.

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[13] Albrecht, Steve, D.B.A. "Threat Assessment Teams: Workplace and School Violence Prevention." FBI Law Enforcement Bulletin. 2010.

Law enforcement can help to assess reported threats or troubling behavior quickly and privately and reach out to available Federal resources as part of the TAT process or separately. The FBI's behavioral experts in its National Center for the Analysis of Violent Crime (NCAVC) at Quantico, VA, are available on a 24/7 basis to join in any threat assessment analysis and develop threat mitigation strategies for persons of concern. The law enforcement member(s) of the HCF TAT should contact the local FBI office for this behavioral analysis assistance.

Each FBI field office has an NCAVC representative available to work with HCF TATs and coordinate access to the FBI's Behavioral Analysis Unit, home to the NCAVC. The analysis focuses not on how to respond tactically to an active shooter incident but rather on how to prevent one. Early intervention can prevent a situation from escalating by identifying, assessing, and managing the threat. The TAT should consult with its HCF administration and develop a process to seek these additional resources.

Generally, active shooter incidents are not motivated by other criminal-related concerns such as monetary gain or gang affiliation. Oftentimes, situations may be prevented by identifying, assessing, and managing potential threats. Recognizing these pre-attack warning signs and indicators could help disrupt a potentially tragic event.

Response: Practical Application of the "Run, Hide, Fight" Model in an HCF Setting

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Regardless of training or directions given, each employee, visitor, and patient will react and respond based on his or her own instincts. Some people may not be able to leave; others may refuse to leave. Some will find comfort in a group; others will face the challenges alone. It would be difficult or impossible for HCFs to inform visitors and patients of every eventuality. HCFs should help employees understand there is no perfect response.

Nobody can or should be instructed that they must stay or they must leave. However, HCFs can help employees better prepare, respond, and recover by discussing the active shooter incident and inviting employees to trust that they will make the best decision they can at the time, relying on their individual circumstances. During an active shooter incident, those present will rarely have all of the information they need to make a fully-informed decision about applying the "Run, Hide, Fight" options.

It is not uncommon for people confronted with a threat to first deny the possible danger rather than respond.

A 2005 investigation by the National Institute of Standards and Technology into the collapse of the World Trade Center towers on September 11, 2001, found that people close to the floors impacted waited longer to start evacuating than those on unaffected floors.[14] Similarly, during the Virginia Tech shooting, individuals on campus responded to the shooting with varying degrees of urgency.[15]

These incidents highlight this delayed response or denial. For example, some people report hearing firecrackers, when, in fact, they are hearing gunfire.

Train staff to overcome denial and to respond immediately. For example, train staff to recognize the sounds of danger, act, and forcefully communicate the danger and necessary action (e.g., "Gun! Get out!"). In addition, those closest to the public address or other communications system, or who are otherwise able to alert others, should communicate the danger and necessary action. Repetition in training and preparedness shortens the time it takes to orient, observe, and act. Upon recognizing the danger, staff or others must alert responders as soon as it is safe to do so by contacting 911 with information that is as clear and accurate as possible.

While personal safety is the primary consideration in any emergency, helping others to safety increases the survivability for all potential victims. Rendering aid can be as simple as rallying likely victims to "Follow me!" or aiding non-ambulatory persons and performing immediate first aid in safer areas. Consideration should be given to children and others who may have difficulty evacuating without assistance.

Active shooter incidents are unpredictable and evolve quickly. Because of this, individuals must be prepared to deal with an active shooter incident before the two, three, or more minutes it may take law enforcement personnel to arrive on the scene. Shooters generally arrive with more ammunition than they could ever use, increasing the urgency for everyone in an HCF to have a plan and act on it as quickly as possible.

When an incident occurs, it is important to follow the EOP and any instructions given, taking into consideration their particular circumstances. The safety of individuals, other staff, patients, and visitors is the most important factor to consider when making decisions.

As the situation develops, staff, patients, and visitors need to be trained to know how to use more than one option in the "Run, Hide, Fight" continuum. Individuals need to learn to decide what action is appropriate based on their locations. The goal in all cases is to survive and protect others, but options will depend on how close individuals are to the shooter. Individuals fearing danger should consider the following guidance in making personal choices and taking appropriate actions.

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[14] Occupants of both towers delayed initiating their evacuation after World Trade Center 1 was hit. In World Trade Center 1, the median time to initiate evacuation was 3 minutes for occupants from the ground floor to floor 76, and 5 minutes for occupants near the impact region (floors 77 to 91).

Averill, Jason D., et al. *Federal Building and Fire Safety Investigation of the World Trade Center Disaster: Occupant Behavior, Egress, and Emergency Communications*. National Institute of Standards and Technology. 2005.

[15] Report of the Virginia Tech Review Panel

While security personnel may be present, in most instances, sworn law enforcement officers may not be on scene when a shooting begins. Providing information on how staff[16] can respond to the incident can help prevent and reduce the loss of life. No single response fits all active shooter incidents; however, making sure each individual knows his or her options for response and can react decisively will save valuable time. The mental rehearsal of scenarios and considering response options in advance will assist individuals and groups in quickly selecting their best course of action.

During an active shooter incident, the natural reaction, even for highly trained individuals, is to be startled, feel fear and anxiety, and even experience initial disbelief and denial. Those present can hear noise from alarms, gunfire, and explosions, and people shouting and screaming. Training provides the means to regain composure, recall at least some of what has been learned, and commit to action. Training to remember Run, Hide, or Fight prevents inaction. Those present can run away from the shooter, seek a secure place where they can hide and deny the shooter access, or incapacitate the shooter in order to survive and protect others from harm. In many instances, an individual might first need to hide and then run to safety when able.

As the situation develops, it is possible that those present will need to use more than one option. **While they should follow the plan and any instructions given by appropriate facility representatives during an incident, they will often have to rely on their own judgment to decide which option will best protect lives.**

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Run

If it is safe to do so, the first course of action that should be taken is to run. Individuals should be trained to run out of the facility or away from the area under attack and move as far away as possible until they are in a safe location. Simply exiting the building and going to an evacuation site via practiced fire drill routes may put individuals at risk.

Despite the complexity of this situation, personnel, patients, and visitors who can evacuate safely should do so. Recent research shows the best method to reduce loss of life in an active shooter incident is for people to immediately evacuate or be evacuated from the area where an active shooter may be located or attempting to enter.[17]

Staff should be trained to:

- Leave personal belongings behind.
- Visualize possible escape routes, including physically accessible routes for patients, visitors, or staff with disabilities and others with access and functional needs.
- Avoid escalators and elevators.
- Take others with them but not stay behind because others will not go.
- Call 911 when safe to do so.

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[16] Please note in this guide that the term "staff" includes, but may not be limited to, employees, licensed independent practitioners, allied health care professionals, volunteers, residents and students in training, and vendors that work in or are frequently in the facility.

[17] Blair, J. Pete, et al. *Active Shooter Events and Response*. Boca Raton, FL: CRC Press, Taylor & Francis Group, LLC. 2013.

Because employees may scatter, they should be given directions on who they should contact in order to account for all employees.

Hide

If running is not a safe option, staff should be trained to hide in as safe a place as possible where the walls might be thicker and have fewer windows. Likewise, for patients that cannot "run" because of mobility issues (e.g., they are unable to leave their bed) hiding may be their only option.

In addition:

- Lock the doors if door locks are available.
- Barricade the doors with heavy furniture or wedge items under the door.
- Those in a specialty care unit should secure the unit entrance(s) by locking the doors and/or securing the doors by any means available (e.g., furniture, cabinets, bed, equipment).
- Close and lock windows and close blinds or cover windows.
- Turn off lights.
- Silence all electronic devices.
- Remain silent.
- Look for other avenues of escape.
- Identify ad-hoc weapons.
- When safe to do so, use strategies to silently communicate with first responders, if possible (e.g., in rooms with exterior windows, make signs to silently signal law enforcement and emergency responders to indicate the status of the room's occupants).
- Hide along the wall closest to the exit but out of view from the hallway (which would allow the best option for ambushing the shooter and for possible escape if the shooter enters or passes by the room).
- Remain in place until given an all clear by identifiable law enforcement.

Consider these additional actions:

- Barricade areas where patients, visitors, and/or staff are located.
- Transport patients in wheelchairs or on stretchers or carry them to a safe location.
- Identify a safe location in each unit before an incident occurs where staff, patients, and visitors may safely barricade themselves during an event.
- Train people in how to lock down an area and secure the unit, including providing a checklist of instructions on the back of doors and by phones.
- Ensure emergency numbers are available at all phone locations.

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Fight

If neither running nor hiding is a safe option, as a last resort and when confronted by the shooter, adults in immediate danger should consider trying to disrupt or incapacitate the shooter by using aggressive force and items in their environment, such as fire extinguishers, chairs, etc. Research shows the strength in numbers as indicated in the earlier-mentioned study where the potential victims themselves disrupted 17 of 51 active shooter incidents before law enforcement arrived.

Speaking with staff about confronting a shooter may be daunting and upsetting for some staff, but great comfort can come from the knowledge that their actions could save lives. To be clear, confronting an active shooter should never be a requirement of any health care provider's job; how each individual chooses to respond if directly confronted by an active shooter is up to him or her.

Interacting with First Responders

Police officers, firefighters, and EMS personnel (i.e., first responders) who come to an HCF because of a 911 call involving gunfire face a daunting task. Though the objective remains the same—protect patients, visitors, and staff—the threat of an active shooter incident is different than responding to a natural disaster or many other emergencies. Emergency calls can involve actual or future threats of physical violence. Information coming in can be inaccurate and conflicting. This violence might be directed not only in or at HCF buildings, students, staff, and areas, but also at nearby buildings off site.

Staff should be trained to understand and expect that law enforcement's first priority must be to locate and stop the person or persons believed to be the shooter(s); all other actions are secondary. One comprehensive study found that in more than half (57 percent) of active shooter incidents where a solo officer arrived on the scene, shooting was still underway when the officer arrived. In 75 percent of those instances, that solo officer had to confront the perpetrator to end the threat. In those cases, the officer was shot one-third of the time.[18] Active shooter incidents are one of the most dangerous situations facing law enforcement today.

Staff should be trained to cooperate and not to interfere with the law enforcement response. When law enforcement arrives, staff—including those providing emergency medical care—and all present must follow directions and display empty hands with open palms. Law enforcement may instruct everyone to get on the ground, place their hands on their heads, and they may search individuals.

The sooner law enforcement is able to discern these threats and react, the more lives can be saved. This is particularly true in an active shooter incident where law enforcement responds to a 911 call of shots fired. Many innocent lives are at risk in concentrated areas. This is why it is critical that HCFs train and exercise with their community partners (e.g., first responders, emergency managers) to identify, prepare, prevent, and effectively respond to an active shooter incident in a coordinated fashion.

As part of the planning process, the HCF's EOP should be shared with first responders, giving first responders vital information before they even arrive on the scene. This should be an up-to-date and well-documented site assessment, as well as any other information that would assist

[18] Ibid.

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them. These materials should include building schematics and photos of both the inside and outside of the buildings, and include information about door and window locations, and locks and access controls.

Emergency responders also should have advance information on locations where they are likely to find patients unable to evacuate, such as the operating room, critical care units, nurseries, and pediatric units. Building strong partnerships with law enforcement, fire, and EMS officials includes ensuring they know the location of available public address systems, two-way communications systems, security cameras, and alarm controls. Equally important is information on access to utility controls, medical supplies, fire extinguishers, and how to access secured or locked areas of the facility.

In actual emergencies, timely intelligence is critical. Staff should be trained to contact the police and share with them essential information, such as the location and description of attackers, types of weapons, methods and direction of attack, and flight of attackers. Law enforcement encourages all calls, and no one should assume that someone else has called. Video surveillance that is accessible to smart phones and other electronic devices must be shared with responding units as soon as practical.

Providing this detailed information to first responders allows them to move through an HCF rapidly during an emergency, to ensure areas are safe, and to tend to people in need. When this information is shared with law enforcement and other first responders before an emergency occurs, agencies can access this information before or as the first responders are arriving on the scene. Law enforcement agencies have secure Web sites, available only to law enforcement, where this information is stored for many businesses, public venues, and other locations. All of these can be provided to first responders and viewed in drills, exercises, and walkthroughs.

Technology and tools with the same information (e.g., a portable flash drive that is compatible with computers used by first responders) should be maintained in secured locations in the facility from which HCF officials can immediately provide it to responding officials or from which first responders can directly access it. The locations of these materials at the HCF should be known by and accessible to a number of individuals. Each HCF should determine which individuals are appropriate, keeping in mind the ultimate goal of ensuring ready access in an emergency.

Likewise, every HCF should have more than one individual charged with meeting first responders to provide them with the HCF site assessment, the HCF EOP, and any other details about HCF safety and the facility. Many large businesses and hospitals have a designated emergency team prepared to gather together and provide first responders with access to utilities, keys, broadcast systems, building schematics, and other vital information. All parties should know the members of this emergency team.

Exercises and Training

Most HCFs practice evacuation drills for fires and take protective measures for tornadoes, but far fewer HCFs practice for active shooter incidents. To be prepared for an active shooter incident, training and exercises should include what to expect and how to react.

Good planning includes training and conducting drills with first responders and facility security teams, including the role of any security or sworn law enforcement officers who are employed in the HCF's emergency department or other areas of the facility. Training and exercises with these

valuable partners are one of the most effective and efficient ways to ensure that everyone knows not only his or her role but also the role of others at the scene. These exercises should include a walkthrough of the HCF to allow law enforcement officials to provide input on shelter sites and be familiar with hazardous areas within the facility (e.g., MRIs and radioactive areas). This will also familiarize first responders with the site, including shelter locations, evacuation routes, and locations where they may find patients who may be unable to evacuate, such as the operating room, critical care units, nurseries, and pediatric units. The facility should also consider and plan for how to address (either treat on site or transfer) critically injured patients from the event. Exercises should, to the extent possible, include people with a variety of access and functional needs and should utilize actors as this provides inaccurate practice.

After an Active Shooter Incident

Once the scene is secured, first responders will work with HCF officials and victims on a variety of matters. This will include treating and transporting the injured, interviewing witnesses, and initiating the investigation. See Appendix A for information on the Health Insurance Portability and Accountability Act of 1996.

Be prepared to implement the mass casualty plan as soon as it is safe to do so. Quick hemorrhage control is an important success factor in saving lives.[19] Have supplies available and set the expectation for staff that they should assist victims as soon as it is safe to do so because the arrival of EMS may be delayed.

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Review the hospital's role in the community's mass fatality plan and be prepared to support this effort. Consider how the presence of victims, injured and uninjured, may affect your HCF's planning and operations.

After the active shooter has been incapacitated and is no longer a threat, human resources and/or management should engage in post-event assessments and activities, including:

- Accounting for all individuals at one or more designated assembly points to determine who, if anyone, is missing or potentially injured.
- Coordinating with first responders to account for any patients, visitors, and staff who were not evacuated.
- Determining the best methods for notifying families of individuals affected by the active shooter, including notification of any casualties; this must be done in coordination with law enforcement.
- Assessing the behavioral health of individuals at the scene, ensuring access to victims resources including distress helplines, Office for Victims of Crimes counselors or employee assistance personnel, and establishing platforms for contact and recovery support.
- Ensuring equal access to all such resources and programs for people who are deaf, hard of hearing, blind, have low vision, low literacy and other communication disabilities and individuals with limited English proficiency.

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[19] Bulger, Ellen, M., et al *An Evidence-Based Prehospital Guideline for External Hemorrhage Control: American College of Surgeons Committee on Trauma*. Prehospital Emergency Care 2014;18:163-173.

- Planning and activating an employee family unification plan, communicating this to employees and providing a safe place, away from press to facilitate its execution.
- Identifying and filling any critical personnel or operational gaps left in the organization as a result of the active shooter.
- Determining when to resume full services.

It is important to note that once the active shooter is apprehended or incapacitated, the situation and the location will be an active crime scene. Nothing should be touched unless it involves tending to the wounded. Discuss the implications of the HCF as a crime scene with local law enforcement officials in advance.

HCF administration and key personnel should plan for an extended, evolving situation and the mass casualty or internal disaster plan may be activated to manage the continuing situation. This may include altering daily activities in order for law enforcement and first responders to adequately investigate and clear the scene, and to restore the facility to an acceptable level for clinical activity. The emergency department may be put on diversion according to local or regional plans. Be prepared to consider Emergency Medical Treatment and Active Labor Act issues.

The HCF EOP should identify trained personnel who will provide assistance to victims, witnesses, and their families. This should include establishing an incident response team (including first responders) that is trained to appropriately assess and triage victims. They will provide emergency intervention services and victim assistance beginning immediately after the incident and throughout the recovery efforts. This team will integrate with state and Federal resources when an emergency occurs.

Federal and state laws mandate the care of victims of crimes in certain circumstances. Therefore, substantial resources and processes are already in place to aid victims and their families, most notably through state agencies, the Department of Justice, and the FBI's Office for Victim Assistance. Prior familiarity with these resources—such as existing, dedicated toll-free numbers for victims and their families—will permit HCFs to immediately provide valuable information to victims, victim families, staff, and others affected by the tragedy.

Within an ongoing and/or evolving emergency, where the **immediate reunification** of loved ones **is not possible**, providing family members with timely, accurate, accessible and relevant information is paramount. The local or regional mass fatality plan may call for the establishment of a family assistance center to help family members locate their loved ones and determine whether or not they are among the casualties. This center should be placed away from media view or exposure. Although the center should also be away from the incident command, it should not be so far away from the incident site that family members will feel detached and abandon the site.

Having family members wait for long periods of time for information about their loved ones not only adds to their stress and frustration, but can also escalate the emotions of the entire group. When families are reunited, it is critical that there are child release processes in place where minors might be involved (e.g., childcare or discharged patients) to ensure that no child is released to an unauthorized person, even if that person is well meaning. The Psychological First Aid section of this document describes in more detail how to prepare for and handle victims' emotional and psychological needs.

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Essential steps to help establish trust and provide family members with a sense of control can be accomplished by identifying a safe location separate from distractions and/or media and the general public, but close enough to allow family members to feel connected in proximity to their loved ones; scheduling periodic updates even if no additional information is available; being prepared to speak with family members about what to expect when reunited with their loved ones; and ensuring effective communication with those who have language barriers or need other accommodations, such as sign language interpreters for deaf or hard of hearing family members.

When reunification is not possible because an individual is missing, injured, or killed, how and when this information is provided to families is critical. Before an emergency, the planning team must determine how, when, and by whom loved ones will be informed if their loved one is missing or has been injured or killed - keeping in mind that law enforcement typically takes the lead on death notifications related to criminal activity. This will ensure that families and loved ones receive accurate and timely information in a compassionate way.

While law enforcement and medical examiner procedures must be followed, families should receive accurate information as soon as possible. Having trained personnel immediately available to talk to loved ones about death and injury can ensure the notification is provided to family members with clarity and compassion. Counselors should be on hand to immediately assist family members.

The HCF EOP should include pre-identified points of contact to work with and support family members (e.g., counselors, police officers). These points of contact should be connected to families as early in the process as possible, including while an individual is still missing but before any victims have been positively identified. After an incident, it is critical to confirm that each family is getting the support it needs, including over the long term.

The HCF EOP should consider printed and age-appropriate resources to help families recognize and seek help regarding a variety of reactions that they or their loved ones can experience during and after an emergency. For example, a family that has lost a child or other loved one may have other family members in the area or at the HCF. It is critical that these families and loved ones are supported as they both grieve their loss and support their surviving family members.

The HCF EOP also should explicitly address how impacted families will be supported if they prefer not to engage with the media. This includes strategies for keeping the media separate from families and staff while the emergency is ongoing and support for families that may experience unwanted media attention at their homes.

Psychological First Aid

Psychological First Aid (PFA) is an evidence-informed, modular approach used by mental health and disaster response workers to help individuals of all ages in the immediate aftermath of disaster and terrorism. PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping.

PFA does not assume that all survivors will develop mental health problems or long-term difficulties in recovery. Instead, it is based on an understanding that disaster survivors and others affected by such events will experience a broad range of early reactions (e.g., physical, psychological, behavioral, spiritual). Some of these reactions will cause enough distress to

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interfere with adaptive coping, and recovery may be helped by support from compassionate and caring disaster responders.

PFA is designed for delivery by mental health and other disaster response workers who provide early assistance to affected children, families, and adults as part of an organized disaster response effort. These providers may be embedded in a variety of response units, including first responder teams, the incident command structure, primary and emergency health care, incident crisis response teams, faith-based organizations, community emergency response teams, Medical Reserve Corps, the Citizen Corps, the Department of Defense Disaster Mental Health Response teams, and other disaster relief organizations. Basic objectives of PFA are to:

- Establish a human connection in a non-intrusive, compassionate manner.
- Enhance immediate and ongoing safety and provide physical and emotional comfort.
- Calm and orient emotionally overwhelmed or distraught survivors.
- Help survivors specifically discuss what their immediate needs and concerns are, and gather additional information as appropriate; offer practical assistance and information to help survivors address their immediate needs and concerns.
- Connect survivors as soon as possible to social support networks, including family members, friends, and neighbors.
- Support adaptive coping, acknowledge coping efforts and strengths, and empower survivors; encourage adults, children, and families to take an active role in their recovery.
- Provide information that may help survivors cope effectively with the psychological impact of disasters.
- When appropriate, link the survivor to another member of a disaster response team or to local recovery systems, mental health services, public sector services, and organizations.

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PFA is designed for delivery in diverse settings. Mental health and other disaster response workers may be called upon to provide PFA in:

- General population and medical shelters to include accommodations in all settings.
- Field hospitals and medical triage areas.
- Acute care facilities (e.g., emergency departments).
- Staging areas or respite centers for first responders or relief workers.
- Emergency operations centers.
- Crisis hotlines or phone banks.
- Mobile dining facilities.
- Disaster assistance service centers.
- Family reception and assistance centers.
- Homes.

- Businesses.
- Other community settings[20].

Training on Psychological First Aid

PFA Training can be provided in person or online. The online version is broadly used and is a six-hour interactive course that puts the participant in the role of a provider in a post-disaster scene. This professionally narrated course is for individuals new to disaster responses who want to learn the core goals of PFA, as well as for seasoned practitioners who want a review. It features innovative activities, video demonstrations, and mentor tips from the Nation's trauma experts and survivors. PFA online also offers a learning community where participants can share experiences using PFA in the field, receive guidance during times of disaster, and obtain additional resources and training.

The *Psychological First Aid: Field Operations Guide* provides information for adults, families, first responders, disaster relief workers, crisis counselors, and volunteers to help survivors immediately in the aftermath of a traumatic event. The guide describes key steps for providing PFA, including how to approach someone in need, how to talk to them, how to help stabilize someone, and how to gather information. Appendices include resources about service delivery sites and settings, provider care, and worksheets and handouts.

Following disasters or emergencies, the PFA Mobile application can assist responders who provide PFA to adults, families, and children. Materials in PFA Mobile are adapted from the *Psychological First Aid: Field Operations Guide* (2nd Edition).

The app allows responders to:

- Read summaries of the eight core PFA actions.
- Match PFA interventions to specific stress reactions of survivors.
- Get mentor tips for applying PFA in the field.
- Self-assess to determine their own readiness to conduct PFA.
- Assess and track survivors' needs to simplify data collection and referrals.

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[20] The content for this section was taken from *Psychological First Aid Field Operations Guide*, which is available at http://www.nctsn.org/sites/default/files/pfa/english/1-psyfirstaid_final_complete_manual.pdf. The Federal Government does not officially endorse the National Child Traumatic Stress Network or its products. These materials have been provided here for educational purposes only and do not replace medical advice from a trained mental health professional.

Appendix A: Information Sharing

This section provides an overview of how the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may impact information sharing in the health care facility (HCF) setting during an emergency situation. Any given emergency situation may or may not involve the use or disclosure of HIPAA-protected health information (PHI). An emergency plan should consider both scenarios. Thus, this section offers some information related to when HIPAA does and does not apply for planners to consider, as appropriate, HIPAA privacy concerns before, during, and after an emergency.

While this section of the guide focuses on HIPAA, planners should be aware of additional Federal and state civil rights and other laws that place restrictions on when and with whom HCFs may share information. One example is Federal civil rights laws, including laws that prohibit discrimination based on disability (Americans with Disabilities Act [ADA] and Section 504 of the Rehabilitation Act of 1973); race, color, and national origin (Titles IV and VI of the Civil Rights Act of 1964); sex (Title IX of the Education Amendments of 1972 and Title IV of the Civil Rights Act of 1964); and religion (Title IV of the Civil Rights Act of 1964). Section 504 and Title II of the ADA, for example, prohibit discrimination on the basis of disability, and generally would prohibit unnecessary disclosures of disability status, or information related to that disability, to third parties. Disclosures may be necessary when an individual presents a significant, articulable threat to others.

HCFs are encouraged to take the time to review these laws and others that apply in their jurisdictions to ensure that they and their partners have a good understanding of when it is acceptable to disclose information without consent.

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Health Insurance Portability and Accountability Act of 1996

What Is HIPAA?

HIPAA and its implementing regulations, commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule, protect the privacy and security of individually identifiable health information, called PHI. Such information is held by health plans, health care clearinghouses, and most health care providers, collectively known as "covered entities," and their business associates (entities that have access to individuals' health information to perform work on behalf of a covered entity).

The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards to protect the privacy of individuals' identifiable health information. In doing so, the Privacy Rule sets forth the circumstances under which covered entities and their business associates may use or disclose an individual's health information,

requires safeguards to protect the information, and gives individuals rights, including rights to examine and obtain a copy of their health records and to request corrections.

A major goal of the Privacy Rule is to ensure that individuals' health information is properly protected while still allowing the flow of health information that is needed to provide and promote high quality health care and to protect the public's health and well-being. Given that the health care marketplace is diverse, the Privacy Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

The Security Rule, or Security Standards for the Protection of Electronic Protected Health Information, establishes a national set of security standards for protecting health information that is held or transferred in electronic form. The Security Rule sets out the technical, administrative, and physical safeguards that covered entities and business associates must put in place to secure individuals' electronic health information. The Security Rule is designed to be flexible and scalable, and technology neutral, so a covered entity or business associate can implement policies, procedures, and technologies that are appropriate for the entity's particular size, organizational structure, and risks to consumers' electronic health information.

The U.S. Department of Health and Human Services Office for Civil Rights has responsibility for administering and enforcing the Privacy and Security Rules.

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How Does HIPAA Apply in HCFs?

A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed by covered entities. A covered entity may not use or disclose PHI, except either: (1) as the Privacy Rule permits or requires; or (2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.

For circumstances that may necessitate the disclosure of PHI during an emergency, the Privacy Rule includes several permissions. Among the most relevant permissions are:

- To report PHI to a law enforcement official or other person reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.
- To report PHI to law enforcement that the covered entity in good faith believes to be evidence of a crime that occurred on the premises.
- To alert law enforcement to the death of an individual when there is a suspicion that the death resulted from criminal conduct.
- When responding to an off-site medical emergency, as necessary to alert law enforcement to criminal activity.
- To report PHI to law enforcement when required by law to do so (such as reporting gunshots or stab wounds).
- To comply with a court order or court-ordered warrant, a subpoena, or summons issued by a judicial officer, or an administrative request from a law enforcement official (the administrative request must include a written statement that the information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used).

- To respond to a request for PHI from law enforcement for purposes of identifying or locating a suspect, fugitive, material witness, or missing person, but the information must be limited to basic demographic and health information about the person.

After an emergency situation has been resolved, a covered entity may need to provide updates to family or other persons involved in an individual's care. The Privacy Rule, in addition to other potentially applicable provisions, permits the use and disclosure of PHI about an individual to persons that were involved in the individual's care or payment, as well as to public or private entities authorized to assist in disaster relief efforts.

During the emergency planning process, if health information to which access may be needed may be covered by HIPAA, consult the guidance and resources below for further information about how HIPAA applies.

HIPAA Guidance and Resources

The Office for Civil Rights has developed, and continues to develop, extensive guidance pertaining to the implementation of HIPAA Privacy Rule and emergency situations. The Office for Civil Rights Web site has guidance about the release of PHI for common emergency preparedness issues and public health purposes, such as terrorism preparedness and outbreak investigations.

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Appendix B: Security

It is important to note here that a significant percentage of our Nation's acute care facilities do not have a full-time security force. That number is even smaller for clinics. Additionally, the characteristics of the existing HCF security and police services vary considerably. However, the following four most common primary types of health and hospital public safety services are:

- **Hospital police department:** An integral part of the HCF that provides law enforcement and other services (e.g., traffic control, building security) to the health care community. All the members of the department are employed by the HCF or local police jurisdiction, and the sworn law enforcement officers of the department also have authority to enforce local, state, tribal, and Federal laws, as authorized.
- **Sworn local, state, tribal, or campus law enforcement:** A local, state, tribal, or campus law enforcement agency that provides law enforcement services to the HCF by contract or agreement.
- **Security department or security operation department:** An agency whose members are employed by the HCF and whose members are not sworn law enforcement officers. Because the members do not have sworn authority, the HCF relies on sworn campus, local, state, tribal, and Federal law enforcement officers for support in criminal matters.
- **Contract security personnel:** A private firm contracted to provide security services to the HCF. The HCF relies on sworn campus, local, state, tribal, and Federal law enforcement officers for support in criminal matters.

Some HCFs have a hybrid of these police and security operations, with some services contracted to private vendors and others maintained as the responsibility of the HCF public safety agency. This can also include a fire department or emergency medical services unit.

Regardless of the type of public safety model utilized by the HCF, the planning team must take into consideration the authorities granted by law to each campus, local, state, tribal, and Federal first responders (e.g., law enforcement agency, fire department, and public health office).

Individual HCFs may have separate police or security departments for different components of the facility, such as the hospital, health clinic, or animal research facility. These different departments may have their own uniforms, insignia, training operations, and policies.

The type of security operation also may vary between residential and non-residential facilities. Many HCFs are decentralized or exist on multiple campuses. These HCFs may have remote centers and facilities located away from the main site. In addition to providing clinical services, off-site locations may house important research and data records. Some hospital public safety agencies are responsible for patrolling areas that surround facilities pursuant to legislation or through formal agreement with the campus, local, state, tribal, or Federal law enforcement authority. This could create legal, jurisdictional, and operational conflicts in preventing and responding to crimes and managing emergencies. Valuable minutes during an emergency can be lost working out such conflicts. Addressing these issues in advance—through the creation and use of an emergency operations plan (EOP)—can save time and lives.

Regardless of these variations, hospital and health care public safety officials and senior administrators should be intricately involved in the creation and approval of the HCF EOP. Each

has critical responsibilities before, during, and after an emergency. To effectively develop and implement a high quality HCF EOP, the planning team should work with all health and hospital public safety components to:

- Inform relevant local, state, tribal, and Federal agencies about the characteristics, strengths, vulnerabilities, and needs of the facility.
- Develop mutual aid agreements and memoranda of understanding with other public safety partners (e.g., those adjoining the HCF's public safety entities, nearby fire departments).
- Participate in campus, local, state, tribal, and Federal activities, including exercises, that address the range of public safety needs.
- Meet with other HCFs to foster information sharing, common prevention and response strategies, and consistency in working with local, state, tribal, and Federal public safety partners.
- Improve interagency coordination, create coalitions, and develop partnerships with relevant campus, local, state, tribal, and Federal emergency management agencies.
- Adopt common incident response strategies, policies, and procedures for use across multiple facilities and sites, as recommended by NIMS.

"This course was developed from the public domain document: Incorporating Active Shooter Incident Planning Into Health Care Facility Emergency Operations Plans – U.S. Department of Health and Human Services."