



Healthcare Preparation for and Response to Local Civil Unrest

Recent incidents of civil unrest have affected critical infrastructure components (including healthcare facilities) in many cities across the U.S. Several have recently experienced incidents, some just once or twice, some for an extended period, and many during the COVID-19 pandemic. Civil unrest can affect traffic (and the ability for staff to safely commute to work); patient and staff access to the emergency department (ED) and other healthcare services; emergency medical services (EMS) safety and hospital access; and patient and staff safety around and inside the hospital. ASPR TRACIE met with representatives from Chicago, Seattle, Baltimore, Minneapolis, Portland (OR), and Washington, DC who shared lessons learned from these incidents and, in some cases, how these lessons have been incorporated into their plans. While the ripple effects of these incidents are felt far and wide, three primary themes emerged during the conversation.

Theme 1: Planning, Traffic, and Supply Chain Challenges

All meeting participants had a plan in place to address civil unrest (e.g., Minneapolis had hosted a Superbowl in 2018; Washington, DC regularly hosts large-scale events, including protests), and most had practiced it on a regular basis. In most sites, hospital incident command centers had been operational for months due to the COVID-19 pandemic. The relationships that were cultivated/enhanced in the command centers helped when sites had to activate their civil unrest plans on top of their ongoing public health emergency response.

Some found their plans to be too focused on facility hardening and protection, and not focused enough (if at all) on the impact these incidents could have on local transportation, let alone the challenges employees faced commuting to and from work and patients faced coming in for treatment. In some cases, governors ordered the closure of freeways in the evening, sometimes without warning, to reduce ingress into and movement around the city. Unfortunately, this had the same effect on healthcare workers; many had to leave for work very early, stay at work late, plan alternative routes, or arrange for backup transportation options to and from work. This improved over time. One site created a hotline staff could call that shared transportation and traffic updates specific to the communities near the hospital.

These closures often pushed traffic to surface streets where protests were taking place, putting patients and staff at increased risk and lengthening ambulance transport times. Healthcare facility leadership encouraged staff to stay over during periods of higher protest volumes. On-call staff who usually take calls from home (e.g., cardiac cath lab workers) were asked to be on-site at some facilities. Some staff were concerned about

One participant shared that home care workers and those who deliver durable medical equipment and supplies to individuals were particularly vulnerable as many patients lived in areas affected by violent protests.

incurring damage to their vehicles while they commuted to work; they were encouraged to use rideshare programs or take public transportation if it was a safe and operational option. At one site, staff were able to use a bridge and tunnel system from other buildings to get to the hospital. Some facilities discouraged their EMS personnel from wearing uniforms during their commute.

Leadership in several cities also shut down public transportation to minimize group movement. Many participants stressed the impact these closures had on a significant proportion of staff who rely on public transportation and could not come to work. Some staff called in from the road because they needed colleagues to vouch for them to law enforcement over the phone so they could travel through the security perimeter to work. In one city, emergency managers hired shuttle buses to pick up staff where public transportation stopped. They also created unique identifying documents for staff, patients, and visitors to allow them to travel to the facility.

Civil unrest incidents exacerbated the already significant impact the COVID-19 pandemic had on the healthcare supply chain in these cities. While most felt their blood supplies were adequate prior to the protests, the injuries sustained during these incidents (e.g., ballistic trauma) that required transfusion caused some concern. Hospitals typically receive blood shipments by ground. At some sites, couriers were not able or willing to drive through active protest areas to deliver product. In some cases, state troopers helped with transport. In other sites, the law enforcement response required by the protests left no officers free to assist with this task. One meeting participant explained that hospitals are rather close together on a hill in the city, and they “share” supplies on a typical day; during these periods, staff continued delivering critical supplies when nearby hospitals ran low.

Pre-planning with local law enforcement as much as possible and through the Emergency Operations Center (EOC) was critical. If that could not occur, stocking up ahead of planned demonstrations or prior to nighttime helped. In one city, personal protective equipment and hand sanitizer was normally stocked in a warehouse within the protest area. Medical staff had to travel to the site during the day when protestors were not around and move supplies to rented locations across the city. Participants shared that many clinics and pharmacies located in their cities were looted and often set on fire. Pharmacies far from the protest areas were also burglarized (likely by offenders capitalizing on low law enforcement resources). This created gaps in access to care and prescriptions that exacerbated inequities.

“ We constantly remind staff to bring their badges home; don’t leave them in lockers—having them on-hand can help them get through security checkpoints set up throughout protest perimeters. ”

Several participants reported incorporating lessons learned from the protests into their facility emergency plans. One hospital created

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Harborview Medical Center (Seattle): Dr. Steve Mitchell, Medical Director, Emergency Department

Hennepin Healthcare (Minneapolis): Dr. John Hick, Medical Director for Emergency Preparedness, and Seth Jones, Emergency Preparedness Program Manager

John H Stroger Hospital of Cook County (Chicago): Patricia Taylor, Director of Emergency Management

Johns Hopkins Medicine (Baltimore): Rob Carter, Senior Director of Emergency Management and Scott Bloodsworth, Director, External Security

MedStar Health (DC, MD, and VA): Craig DeAtley, PA-C, Director, Institute for Public Health Emergency Readiness

Northwestern Memorial HealthCare (Chicago): Amy Russer, Director, Emergency Management and Business Continuity, and George DiLeonardi, Vice President of Security and Emergency Management

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a civil unrest playbook that covers staff support, communications, and other components. Others have updated mission continuity plans that allow for customization at the local level. With so many competing priorities (in the ED especially), some felt it was particularly important to update and exercise plans for evacuating versus sheltering in place. And to prevent clinics from being targeted again, participants reported removing the narcotics supplies in those facilities, posting signs indicating those narcotics had been removed, and/or adding hurricane shutters to minimize property damage.

“ **Most injured protestors were being delivered by other armed protestors, some armed with an AR-15.** ”

“ **Police were definitely viewed as the enemy.** ”

Ann & Robert H. Lurie Children’s Hospital of Chicago created a comprehensive hospital emergency management internet site using SharePoint, where users can access a variety of resources on hospital incident command including job action sheets, flowcharts, and playbooks. They have also created a presentation for staff who rotate as administrator on call. One meeting participant noted that civil unrest and pandemics were not “on the radar” five years ago; all participants emphasized the need for healthcare facilities to continue to prepare and plan for all hazards and to integrate internal and external partners into all aspects of planning.

Most agreed that funding for exercises remains a challenge. While healthcare systems and individual facilities have plans, being able to exercise them is often difficult due to competing interests. One participant noted the importance of keeping track—in writing supported by photographs—of everything impacting expense/revenue from the beginning of the incident response phase. He noted that his system is feeling more pressure from their insurance company to demonstrate they are making every effort to minimize costs and document loss.

Theme 2: Relationships with Law Enforcement and the Military

Partnerships with law enforcement—created before the incidents—proved extremely helpful, particularly when it came to providing hospital security, intelligence and real-time information, and assistance with getting staff through checkpoints. Those participants who had not established a relationship with law enforcement before the incidents found that creating one helped with air and ground patient transport as well as getting staff to and from work. Some participants reported having worked closely with key police personnel during past protests and having a contact in the local or state fusion center who shared information that could have an impact on local healthcare. In many cases, law enforcement precincts were located within blocks of the healthcare facility. Some of those buildings were targeted by protestors, so they were shut down; this had a ripple effect on healthcare facility security and emergency management staff who were used to calling on local law enforcement for more immediate assistance.

Healthcare Security Providers

The nature and source of healthcare security varies across the country. Some participants have been working with law enforcement to address civil

While air transport of patients and supplies is usually an option when roads are closed, some cities had to ground helicopters due to protestors—who perhaps thought they were targeting law enforcement helicopters—aiming lasers at the cockpit.

When freeways were closed, law enforcement in one city shared information from air (drone) surveillance with EMS.

During National Preparedness Month (September), MedStar Health provided every shift a 30-minute review of their mass casualty incident plan and their unit-based evacuation plans. Their goal was to reinforce all hazards planning, which had been sidelined a bit during the pandemic.

“Plan, practice, and pray you don’t have to do it twice.”

Much of the recent civil unrest across the U.S. was in response to police brutality. Some staff faced moral dilemmas when working so closely with law enforcement. Others noted having to balance the need for uniformed officers to protect patients and staff between the drop off area and the ED against the threat faced by simply being perceived as associated with law enforcement.



unrest for two decades. Some have armed officers; many do not. Others employ on or off-duty law enforcement to provide security and others use private firms or a combination. The size of some of the healthcare facilities called for a larger law enforcement presence than could be provided—one hospital that spans several city blocks had 50 posts on the inside and 40 on the outside; many entrances were closed, and staff had to adjust access points. Another challenge participants encountered regardless of the type of security they used was a shortage in staff and the inability to hold security staff over or mandate that they switch to 12-hour shifts. One site deputized “bouncers” who were posted at the buildings’ many entrances. Another system purchased riot gear for their security personnel.

One hospital provided law enforcement officers space in secure garages to stage, change shifts, and take breaks. This benefited both parties—police had a safe place to go, and they were on-site should the hospital need them.

Staff and Patient Safety

While transportation was a challenge, so was protecting access to the healthcare facilities, especially when close to 10,000 people participated in a protest. Hardening entrances proved difficult for those whose hospitals were close to or in the middle of protest zones.

Many marchers impeded access to healthcare facilities. A healthcare worker from one city said that when they knew tensions were rising, they reached out to local law enforcement to collaboratively pre-plan primary and alternate routes for their ambulances. Law enforcement then staged along those routes to ensure ambulances could make it through. Hospital staff also performed building sweeps, looking for improvised explosives, equipment, and rocks staged around campuses. Meeting participants noted that most of the violence was not related to organized protests but evolved organically around crowds and individuals, particularly when there was confrontation with law enforcement. Agitators were just as likely to attack fire, EMS, and hospitals as law enforcement personnel; being part of a healthcare mission did not confer any protection in these instances.

Two participants mentioned EMS using strike teams to rapidly secure an area around a patient and determine if they required transport. In one case, the teams were comprised of three EMS vehicles including paramedics, an EMS physician, EMS supervisor, and National Guard personnel. Depending on circumstances, some areas could not be safely entered by EMS personnel and the caller would be encouraged to get the patient to a safer area and re-call 911 or find private transport.

“Street medics” aligned with the protestors and independent of the 911 response are becoming increasingly common. During ongoing protests or planned events successful liaisons can be made between these personnel and EMS to develop “ground rules” and expectations as well as share information, as practiced in Minneapolis/St. Paul during the 2008 Republican National Convention. These “medics” have highly variable training but provided initial care and transported patients to the healthcare facility. In some cases, they were escorted by their own self-formed, often armed, “security teams.” These personnel typically did not engage with EMS or write reports. Getting the patient into the ED proved challenging at these sites, especially if facility security was in uniform and armed. In some cases, armed law enforcement would monitor the situation but remain out of sight, and healthcare facilities did not let their staff retrieve patients until non-weapon carrying, plain clothes-wearing security team members cleared the scene.

One healthcare facility sent armed officers outside to clear the scene before ED staff retrieved patients and kept unarmed security providers in the facility.

When Police are the Patients

When officers are injured on the job, they do not typically arrive to the hospital alone; they are accompanied by their colleagues who often stay to provide support. During these incidents of civil unrest—the bulk of which were based on anti-law enforcement sentiment—many officers were injured and had to receive treatment. Hospitals faced several related challenges:

- Injured officers were brought to the hospital in police vehicles, not ambulances.
- Keeping injured uniformed officers separate from injured protestors was essential to preventing conflict inside the hospital.
- COVID-19 visitation rules prohibited officers from waiting with their injured colleagues; they ended up waiting outside.



One EMS system placed one or more armed National Guard members in each ambulance to protect EMS staff when police were not available to respond to these calls. They felt that armed soldiers were a significant deterrent to the threats EMS providers were facing and that the rock-throwing and other incidents declined markedly after they were added. Soldiers were critical to creating safe space on scene for EMS to assess patients and provide care and also helped protect hospitals in the city during unrest.

Some sites allowed staff to work from home, if practical. One site provided guidance related to the “See Something, Say Something” initiative. Other ways participants protected staff and patients included:

- Closing clinics early
- Enacting facility lockdown procedures as necessary
- Maintaining COVID-19 limits on patient visitation
- Grounding helicopters to prevent injury from lasers and drones

Even though healthcare has had to quickly innovate to meet the technological demands associated with the COVID-19 pandemic, participants noted having to update infrastructure to help with their civil unrest response (e.g., upgrading to new equipment, new cameras, improving access control).

Information Sharing

Understandably, healthcare staff in these cities wanted reliable, timely information about the protests in general, the effects on traffic, and their ability to remain safe during their commute and once they were at work. In some cities, EMS staff who had pre-existing partnerships with law enforcement or mutual aid compacts with strike teams received information ahead of time that allowed them to prepare “high-threat” hospitals (i.e., those located in the more volatile area). This information was shared through the hospital incident command center and team.

Another meeting participant stated that while his system has a good relationship with local law enforcement, “we know we are never given too much information; we have to push to get it.” His system uses a liaison officer who monitors local television and radio stations for related information. Others mentioned monitoring social media (e.g., Twitter and Twitch) for live streams and to access crowd sourcing cameras.

Healthcare coalitions (HCCs) were mentioned as another tool for sharing information. One participant noted that the HCC in their city held teleconferences during the civil unrest incidents, allowing healthcare representatives to request information from the public safety staff on the calls.

In some cities, mayors’ offices held regular security briefings, where many participants shared concise updates, minimizing duplication of effort, and ensuring all parties were on the same page.

One participant noted that during these incidents, they realized that law enforcement radios did not work in their 22-story building. That led to the hospitals putting functional radios in a go-bag that is stored by the front entrance, accessible to local police. Together, they also purchased an iPad

Injuries Incurred during Civil Unrest

Law enforcement used a variety of “less-lethal” methods to disperse crowds (e.g., tear gas, pepper spray, and rubber bullets). In Minneapolis, for example, so much spray was used that a military air transport plane had to deliver more.

Many injured protestors came to the ED covered in spray and their clothes were removed and bagged before treatment. If the exposure was relatively minor, healthcare workers used wipes and/or a dampened washcloth to remove residue. It is important for healthcare facilities to be prepared to decontaminate groups of protestors upon whom chemical crowd control agents were used before they enter the ED.

High volumes of gunshot wounds were seen. Patients also sustained significant burns from fires and accelerants, as well as skull and other bone fractures, eye, and other injuries from being struck by rubber bullets (which have since been banned in several U.S. cities).

Meeting participants shared that groups of agitators traveled between Seattle and Portland (OR). Accessing their social media accounts was challenging, and the groups started using cryptic messaging and posters. Local emergency management and healthcare facilities relied heavily on information shared by the fusion center.



and loaded security camera software on it, allowing law enforcement the ability to monitor cameras upon arrival. Another participant shared that they had put life safety plans on thumb drives so that law enforcement could review them floor-by-floor, as necessary.

Still, several cities reported challenges associated with accessing accurate information and staff ended up unintentionally sharing rumors and second-hand information gathered from social media. Others had to rely on information gleaned from telephone calls from their cities' police and fire departments.

Theme 3: Internal Communications

Internal communication is key to staff safety, regardless of the hazard.

Meeting participants shared the different strategies they used to keep staff apprised of the impact civil unrest incidents were having on the hospital and surrounding communities. Some participants sent text alerts that listed areas to avoid, specific entrance closures, and building lockdowns. These were sent judiciously to avoid overwhelming already incredibly busy staff. In one city, emergency managers from several hospitals used group text messaging software to share timely information. Mass communication systems were used when hospitals need to reach remote and on-site employees at one time.

Some participants reported using a dark site or portal as more secure ways to share updates (e.g., regarding alternate transportation). Staff were asked to place these programs on their smart phones, enabling them to access information regardless of location.

Reaching “everyone” proved challenging, however. Some mentioned that homecare providers and satellite ambulatory locations were not kept apprised during these incidents; they were hoping for location-specific information and even if it was available, it was difficult to share it. One participant noted that they had to “draw a line in the sand” when it came to over-communicating as the operational tempo remained high for security staff; after a while, emergency management steered staff towards traffic management apps so they could locate information on their own.

Participants also emphasized the importance of using plain language and not “codes,” particularly during a pandemic, when healthcare staff are working in multiple facilities. They also encouraged the use of free communication platforms (e.g., Teams, Zoom) to quickly bring a group together virtually to discuss a specific incident or to have weekly meetings. One participant site mentioned training all incident command staff on how to use a platform; another touted the value of seeing colleagues face-to-face, even if on a screen.

Conclusion

Civil unrest incidents have ripple effects on city infrastructure, residents, and commuters. These incidents create fear among healthcare staff and are dynamic and often develop rapidly and unpredictably. Knowing your healthcare facility's (and local first responder) plans, possible contingencies, and resources available to use in a response is critical to adapting to these fluid circumstances and maintaining staff and patient safety.

Best Practices by Theme

Theme 1: Planning, Traffic, and Supply Chain Challenges

- Cultivate relationships with colleagues before an incident occurs.
- Anticipate and plan for challenges employees and patients will face when reporting to work or coming in for treatment.
- Encourage staff to use rideshare programs to commute to work.
- Discourage EMS personnel from wearing uniforms during their commute.
- Develop an agreement with a shuttle bus company; have them pick up staff where public transportation stops to ensure a safe, reliable commute.

Related Resources

[Resources for Hospitals During Civil Unrest](#)

[Civil Unrest During a Pandemic-Notes from Minneapolis](#)

[Civil Unrest Tip Sheet](#)

- Create identifying documents for patients and visitors to allow them seamless travel to the facility.
- Stock up on supplies ahead of planned demonstrations or in the light of day.
- Create a civil unrest playbook and exercise it.
- Update and exercise plans for evacuating versus sheltering in place.
- Remove narcotics supplies from clinics located in “hot zones;” post signs indicating as much.
- Add hurricane shutters and use other hardening strategies to minimize property damage.
- Develop an app for staff that includes easily accessible resources on hospital incident command (e.g., job action sheets, flowcharts, and playbooks).
- Continue to prepare and plan for all hazards and to integrate internal and external partners into all aspects of planning.
- Document—in writing supported by photographs—everything impacting expense/revenue from the beginning of the response phase.

Theme 2: Relationships with Law Enforcement and the Military

- Establishing solid relationships with local law enforcement (including fusion centers) can help you obtain timely information and intelligence, allowing you to tailor your response.
- Request and share information through the hospital information center and team and HCCs.
- Consider purchasing riot gear for facility security personnel.
- Provide law enforcement officers space in secure garages to stage, change shifts, and take breaks.
- Collaboratively plan primary and alternate routes for ambulances with law enforcement.
- Have security conduct building sweeps, looking for improvised explosives, equipment, and rocks and other weapons staged around campuses.
- If protesting groups have their own “medics,” EMS can liaise with them ahead of time to develop “ground rules” and expectations and share information.
- Consider keeping armed law enforcement out of sight (while they continue monitoring the situation) versus having a visible presence; this depends on the location/situation.
- Do not allow staff to retrieve patients from personal vehicles until non-weapon carrying, plain clothes-wearing security team members clear the vehicle/patient.
- Place armed National Guard soldiers in ambulances to protect EMS staff when police are not available to respond to EMS calls.
- Enact facility lockdown procedures as necessary.
- Close clinics early.
- Maintain COVID-19 limits on patient visitation.
- Ground helicopters to prevent injury from lasers and drones.
- Update infrastructure to help with civil unrest response (e.g., upgrade equipment, improve access control).
- Monitor local television, radio stations, and social media for information related to unrest.
- Create go-bags for law enforcement that include radios and iPads with loaded security camera software and life safety plans on them. Store these bags by the front entrance.

Theme 3: Internal Communications

- Send text alerts that list areas to avoid, specific entrance closures, and building lockdowns.
- Use mass communication systems when you need to reach remote and on-site employees at one time.
- Consider using a dark site or portal that can be activated during an event for secure, immediate communication; encourage staff to load shortcuts/apps on their handheld devices.
- Keep all healthcare providers, including homecare and satellite ambulatory locations, apprised during these incidents.
- Use plain language and not codes during critical incidents.
- Make the most of free communication platforms (e.g., Teams, Zoom) to quickly bring a group together face to face, virtually.