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What's the Plan? Exploring the Bounds of a Health-Care Standard of Preparedness for Florida Hospitals: A Policy Analysis

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Policy Analysis

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Abstract

Hurricane Katrina uncovered a potential new theory of liability for the health-care industry—failure to plan. Today, the issue remains unresolved: how does a hospital define its duty of preparedness? Research shows there are over 13 definitions for hospital preparedness, multiple types of risk, and arbitrary hospital assessment tools that are not based on empirical data. In the absence of a clear definition for health-care preparedness, this article proposes a "reasonable under the circumstances" test to evaluate alleged liability for failure to plan and similar claims of negligence. In addition, translational science is proposed to aid in the development of a health-care standard of preparedness through a 5-phase evidenced-based, multi-disciplinary process.

A lack of emergency preparedness served as the basis for nearly 200 lawsuits in Louisiana in the aftermath of Hurricane Katrina. "Kristin McMahon, an attorney and chief claims officer for IronHealth," questioned whether "[t]his could be a new theory of liability against healthcare institutions."[1] The general allegation was that "corporate failure to plan adequately for flooding and implement evacuation constituted negligence or medical malpractice."[1] On March 23, 2011, on the eve of trial in *LaCoste v. Pendleton Methodist Hospital, LLC*, Tenet Healthcare settled a lawsuit for failure to plan, among other causes of action, to avoid a negative judgment.[2] Tenet Healthcare settled because it was unable to answer 1 pivotal question: "How prepared do hospitals have to be for the worst possible circumstances?"[1,2] Nearly 15 years since Hurricane Katrina revealed the lack of a health-care standard of preparedness, we are still no closer to defining this unique area of liability.

The absence of a clear standard of care for health-care disaster planning—referred to as a health-care standard of preparedness in this article—is cause for tremendous alarm for 2 reasons. First, and foremost, damages may not be capped. For instance, the Supreme Court of Louisiana ruled that these lawsuits were general negligence claims, which meant that caps on damages imposed in medical malpractice claims did not apply.[1] While not binding on all states, Louisiana's decision may serve as a guidepost for future cases. As such, in the absence of available caps, insurance companies could face a substantial increase in risk exposure. Second, a health-care entity would be forced to defend claims without a formalized method of evaluating precisely how it breached its duty of preparedness. In this regard, Hodge and Brown[2] cautioned that "assigning liability broadly in future cases invites superfluous claims that propel defensive preparedness maneuvers without necessarily improving patient outcomes." The authors reasoned that "[t]agging hospitals with liability for all patient harms that, in hindsight, could have been prevented by better preparedness creates a nearly impossible legal standard for entities to meet."[2]

In a more recent call-to-action, it was posited that a health-care standard of preparedness be even higher than the standard applied to physicians.[3] This position, however, is not practicable. The fluid, sudden, and sometimes unexpected nature of emergencies, in addition to the multitude of varied circumstances in each scenario, advocates consideration of a more flexible standard.

Despite this arbitrary push to create a health-care standard of preparedness, there are several significant obstacles to overcome. For instance, studies show there is no comprehensive tool for evaluating hospital disaster preparedness (HDP), and those that do exist, were not developed based on empirical data.[4–7] Moreover, Verheul and Duckers[8] discovered 13 different definitions of HDP and 22 different ways hospitals have operationalized preparedness. This disparity underscores the incongruence on what constitutes HDP.

The purpose of this article is not only to explore the current state of knowledge concerning HDP, but also to propose a legal test to guide analysis of alleged liability. Specifically, this article proposes a "reasonable under the circumstances" test for claims alleging failure to plan and similar causes of action.

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Table 1. Translational science pathway towards a healthcare standard of preparedness.

T-0	Question under analysis, "What is a healthcare standard of preparedness?"
T-1	Perform a scoping review for data, such as characteristics, actions, data points, etc.
T-2	Present statements developed from the T-1 phase to Delphi experts to reach consensus.
T-3	Implement consensus-based guidelines for further development and/or testing.
T-4	Study the guidelines for outcomes of development, implementation, and patient care.
Legend: T means Translate	

Understanding the Context of Why Declaring a One-Size-Fits-All Health-Care Standard of Preparedness Is Premature

Before we (broadly defined as the emergency management, public health, and legal communities) can answer the question, "What constitutes a healthcare standard of preparedness?", we must first ask ourselves if what we have in place is sufficient to construct this standard. Research suggests the answer to the latter question is "no," because there is no consensus in the field on how to define hospital preparedness.

Hospital preparedness is governed by several federal, state, local, and regulatory laws and benchmarks.[9] For example, in 2003, following the events of September 11, 2001, Homeland Security Presidential Directive 5 required the adoption of the National Incident Management System (NIMS) as a condition to receive federal preparedness assistance funding.[10] Pursuant to this directive, health-care organizations are required to implement NIMS to be eligible to apply for grant funding.[10,11] Nonetheless, there is no standard format for implementation.

Similarly, the Pandemic and All-Hazards Preparedness Act of 2006 authorizes the Department of Health and Human Services (DHHS) to withhold emergency preparedness funds from hospitals that do not meet certain benchmark requirements.[11,12] The DHHS' Centers for Medicare and Medicaid Services—under its Emergency Preparedness Rule—also requires participating hospitals to implement an emergency preparedness program that addresses 4 core elements: (1) risk assessment and planning, (2) policies and procedures, (3) communication plan, and (4) training and testing.[13] Other critical regulatory bodies include The Joint Commission, the Occupational Safety and Health Administration, and the National Fire Protection Agency, none of which define HDP.

At the state level, Florida's Legislature enacted Section 395.1055(1)(c), Fla. Stat.[14] Under this section, hospitals must develop a comprehensive emergency management plan (CEMP).[14] Additional guidance on development of a CEMP plan is found in Chapter 59A-3.078 of the Florida Administrative Code,[15] promulgated by the Agency for Healthcare Administration, which is responsible for, among other tasks, licensure of the state's health-care facilities.[16]

Notably absent from these laws, regulations, and benchmarks, however, is a definition for what constitutes HDP. While research explores a variety of unique characterizations for HDP,[4,7,8,17–19] the concept of "risk" is not a universal term. Instead, "separate risks exist for: (1) the existence of a hazard; (2) the transformation of a hazard into an event; (3) the transformation of an event into damage; and (4) the transformation of damage into a health disaster."[20]

Because existing laws and regulations offer little clarity on this issue, the logical place to turn for guidance is existing tools that assess HDP. However, these tools do not provide as much consistent guidance as one might expect. Heidaranlu et al.[5] evaluated studies on 10 hospital preparedness assessment tools. Most of these tools "dealt with structural and nonstructural preparedness,"[5] but left out "the functional aspect of [HDP] (eg, planning, supply sources, managerial structures, and business continuity)."[5] The absence of these elements leads to an imbalanced review of HDP.

Another inconsistency identified was the disparity in content evaluation.[5] The number of questions or items assessed in these tools varied from as few as 20 to as many as 145.[5] It was also discovered that "most of the reviewed tools had not been developed based on empirical data."[5] Prior research, as well as more recent studies, have noted similar inconsistencies in content evaluation.[4,6–8,17–19,21,22] If assessment of HDP is not consistent, measurable, and based on empirical data accepted in the public health and emergency management communities, then these tools should not serve as the basis of a legal health-care standard of preparedness due to their ambiguity and unreliability.

Proposed Policy: A Reasonableness Test Accommodates Incident-Specific Circumstances

It is evident that the public health and emergency management communities, as well as federal, state, and regulatory bodies, have some more work to do before a consensus can be reached on how to define HDP. Until a consensus is reached, and perhaps even after a definition is secured, the notion of reasonableness should serve as the basis for a health-care standard of preparedness.

Looking to the matter of *LaCoste v. Pendleton Methodist Hospital, LLC*, the Supreme Court of Louisiana found a claim of failure to plan arose under general negligence and not medical malpractice. "Negligence, in general, is legally defined as 'the standard of conduct to which one must conform . . . [and] is that of a reasonable man under like circumstances.'"[23] Circumstances surrounding a disaster involving a hospital facility are unique to each facility. For example, Florida has approximately 321 hospitals located in diverse geographic areas.[24] While each location may experience the same hazard, such as a hurricane, the threat faced by each facility will vary. In addition to geography, other incident-specific considerations include vendor availability, staff and resource availability, access to funding, and access to alternate sources of electricity, potable water, medications, food, and personal protective equipment.

Adopting a health-care standard of preparedness that does not address situation-specific disparities could create a standard that is unreliable, vague, and prejudicial. Instead, a hospital should be held responsible only for what a hospital in like circumstances should have done. This is because a hospital in a rural community, for example, will not prepare in the same way (nor could it) as a hospital in downtown Miami.

Recommendations for Developing a Health-Care Standard of Preparedness

In light of the lack of consensus on what constitutes HDP, a holistic and balanced approach toward defining a health-care standard of

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preparedness is recommended. While development of a legal standard can be a lengthy process, one that may eventually lead to legislative intervention, a defined path may be possible through application of Translational Science. Translational science "seeks to produce more meaningful, applicable results that directly benefit human health."[25] A possible pathway toward creation of a healthcare standard of preparedness is outlined in Table 1. In the end, a well-balanced approach is fundamental to the creation of effective and enduring policy.

Declaration of Conflicting Interests. The author has no conflict of interest to declare.

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