Five Years of Changes on the Receiving End of a Disaster

Geographic circumstances: I was on duty 80 miles from flooded hospitals during Hurricane Katrina and remained at the same location.

About the author: I am a graduate of the University of Texas Medical School at Houston (UTMSH), and I completed my pediatric residency and neonatology fellowship at the University of Colorado Health Sciences Center. Before moving to Baton Rouge in 1993, I was a faculty member in the department of pediatrics at UTMSH. I am the founder and president of Infamedics, a private practice consisting of 9 neonatologists and 6 neonatal nurse practitioners. I am chief of neonatology at Woman’s Hospital and Ochsner Medical Center–Baton Rouge. I serve as clinical faculty for the Our Lady of the Lake pediatric residency program and the department of pediatrics at Tulane School of Medicine. I am active in legislative issues and have served as a chairman of the Advocacy and Medicaid Policy committees for the Louisiana chapter of the American Academy of Pediatrics. I am the current chairman of MedicineLouisiana Inc.

Hurricanes Katrina and Rita affected the city of Baton Rouge, Louisiana, as well as many other cities in many ways. For some, it was an increased population, whereas others found a sense of community in helping those less fortunate. Baton Rouge experienced all of this and much more.

In a previous article published in Pediatrics after the storms, I highlighted the challenges of serving as an evacuation center for hospitalized patients and the perceived shortfalls of the current evacuation plan at that time. Since 2006, significant discussions and planning for evacuations have ensued and resulted in the culmination of procedures overseen by individual hospitals, local governments, the office of the governor, the Louisiana Department of Transportation and Development, and the Louisiana Department of Health and Hospitals (DHH). Hospitals and nursing homes are primarily responsible for the evacuation of their patients and must have policies in place as part of state licensing requirements. When those capabilities are exceeded, the local government is the first to assist. As the need arises, there is now a hierarchical response from state and federal resources. For the general population, the development and implementation of the Catastrophic Supplemental Plan assists local agencies with evacuations. For hospitalized patients, the DHH has developed the Medical Institution Evacuation Plan (MIEP) in the event that multiple hospitals must evacuate concurrently and “normal” transfer agreements cannot be honored or when the needed crisis response is beyond the existing capabilities and resources (Louisiana DHH, Office of Emergency Preparedness, written communication, 2010). The MIEP was developed after Hurricane Katrina and is an evacuation plan for hospitals in case of a catastrophic event that forces a crisis response beyond their capabilities.
and resources. This plan was activated before Hurricane Gustav’s landfall in 2008 and recently underwent its yearly drill in May 2010. At the local level, hospitals have increased emergency power capabilities and the provision of emergency supplies.

There has been recognition at all levels that the requirements for the care and evacuation of hospitalized neonates and expectant mothers are different from those of most adult patients. As such, Woman’s Hospital has been designated as the coordinator of neonatal and high-risk obstetrical patient evacuations in coordination with the Louisiana Emergency Support Function 8 Health and Medical Response plans and the Federal Emergency Management Agency. The result of this designation officially “names” a specific entity (Woman’s Hospital) to focus on mothers and infants during an evacuation and will allow a more coordinated effort and use of state and federal resources if needed. This focus did not exist for Hurricanes Katrina and Rita and was most welcomed by those of us caring for this population.

On a personal practitioner level, our group (Infamedics) has also equipped itself to better face similar situations in the future. We have increased the data-storage redundancy and off-site capabilities of our hardware for our software systems used in the NICU. Both locations are equipped with emergency power. We have purchased satellite phones for key members of our group including office staff to ensure proper coordination of efforts before and after a storm. Radio phones with a 40-mile radius for use during the actual storms will allow the physicians in the hospital to communicate with other members of the group at home to coordinate the poststorm response, because satellite radios are not effective during this time.

In addition to the formalization of evacuation plans, a positive outcome of the hurricanes has been the commitment to graduate medical education in Baton Rouge. The existing teaching programs in New Orleans suffered significant losses after Hurricane Katrina. Through much hard work from our colleagues in New Orleans, these programs are definitely on the mend. Immediately after Katrina, residents from multiple programs, not just pediatrics, sought to continue their training in Baton Rouge. This brought with it 2 things: first, the realization that the future pool of Louisiana physicians would leave the state or would not choose to stay for further training; and second, the beginnings of discussions for increased cooperation for training between community providers and existing training programs in New Orleans. This cooperation continues today in multiple specialties with residents spending training months in both New Orleans and Baton Rouge. More important is that, for pediatrics, a new residency program was started at Our Lady of the Lake Regional Medical Center, and the newborn and NICU rotations occur at Woman’s Hospital. The inaugural class of 8 interns began in July 2010. For many involved, the interaction with residents and medical students has presented a new set of challenges, but this time there has been a much more enjoyable outcome than that of Hurricanes Katrina and Rita.

The training program has improved the communication and collegiality among the pediatric community. Although previously always present at a patient’s bedside, it now extends to many of the aspects of a training program such as curriculum planning, community involvement in the residency, and faculty development in both the clinical and research aspects of care. For Baton Rouge and Louisiana, the pediatric residency program represents the “rainbow” after the storm.

REFERENCES

2. Act 540, 2006 regular session, Louisiana State Legislature
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