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Opening Our Doors for All Newborns: Caring for Displaced Neonates: Intrastate

Steven B. Spedale

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Caring for Displaced Neonates: Intrastate

Steven B. Spedale, MD, FAAP

President, Infamedics, Baton Rouge, Louisiana; Center for Newborn and Infant Care, Woman's Hospital, Baton Rouge, Louisiana

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WOMAN'S HOSPITAL in Baton Rouge, Louisiana, one of the first women's specialty hospitals in the nation, is a 225-bed, private, not-for-profit organization that delivers more than 8000 infants each year. Sick newborns and infants less than 1 year of age are cared for in the 83-bed Center for Newborn and Infant Care, comprised of a level III-C NICU,¹ special care nursery (level II), developmental nursery, infant care center, and neonatal surgery center. A private physician group consisting of 9 neonatologists and 2 neonatal nurse practitioners (NNPs) provide in-house coverage on a 24/7 basis. The hospital employs 4 NNPs to serve as transport NNPs.

The Louisiana Office of Emergency Preparedness (OEP) designated Woman's Hospital as the referral center for high-risk obstetrical patients and neonates for both Hurricanes Katrina and Rita. In a period of 5 days, 87 neonates were transferred to Woman's Hospital during Hurricane Katrina, and transports were arranged for an additional 34 infants to other facilities. Twenty-one neonates were transferred to Woman's Hospital during Hurricane Rita.

AUGUST 26: 3 DAYS BEFORE LANDFALL

Peak Census: 61; Midnight Census: 56*

Katrina, still in the Gulf of Mexico, became a category 2 hurricane, and by 11 PM, the landfall forecast was for just east of New Orleans, Louisiana.² We knew Baton Rouge would experience some type of adverse weather. The Hospital Emergency Incident Command System contains 4 increasing states of storm readiness based on the type of tropical storm/hurricane watches and warnings issued for Baton Rouge. Level 2 was implemented, which included fueling of emergency power generator tanks, establishment of alternate communications, updating departmental emergency call lists, stocking of hospital linen, replenishment of emergency food and drinkable

water supplies, battery charging on portable equipment, and an evaluation of current medication supplies in the pharmacy, with procurement of additional needed emergency medications.

AUGUST 27: 2 DAYS BEFORE LANDFALL

Peak Census: 59; Midnight Census: 54

Katrina became a category 3 hurricane. During the day, the Louisiana OEP was activated, and mandatory evacuations for some parishes south of New Orleans were issued. At 10 PM, the National Hurricane Center issued a warning suggesting that Katrina was moving in a western direction toward an area that included New Orleans. Woman's Hospital moved to level 3 storm readiness, opening the operations center for the hospital. This area contained multiple modes of emergency communication, televisions, emergency power, and computers with Internet access. Additional hospital preparations included establishment of emergency radiology capability, provision of alternative communications in case telephone service to the hospital was interrupted (800 radio system, HEAR Radio system, Ham radio operator), assisting physicians in making rounds to discharge as many patients as possible, obtainment of additional patient

* The peak census is the total number of patients seen daily, and the midnight census is the number of patients after admissions and discharges.

Abbreviations: NNP, neonatal nurse practitioner; OEP, Office of Emergency Preparedness; OLOL, Our Lady of the Lake; LSU, Louisiana State University

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Address correspondence to Steven B. Spedale, MD, FAAP, PO Box 45171, Baton Rouge, LA 70895-4171. E-mail: steve.spedale@infamedics.com

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care supplies, identification of physicians who were on-call for each physician group, identification of physicians who were willing to stay at the hospital or make themselves readily available to the hospital during the storm, and establishment of an employee labor pool.

AUGUST 28: 1 DAY BEFORE LANDFALL

Peak Census: 58; Midnight Census: 54

Katrina was a category 5 hurricane by 10 AM, which prompted New Orleans' Mayor Nagin to issue a mandatory evacuation of the city except for those in prisons or hospitals and tourists, officials, and media. By 5 PM, the state police estimated that 500 000 vehicles were evacuated from New Orleans. Although we received a transport request from East Jefferson General Hospital on that evening, we were unable to comply because the evacuation was taking place on all lanes of Interstate 10 in and out of New Orleans, and the weather was deteriorating. The backup neonatologist came into the hospital that night in case the 4 daytime neonatologists would not be able to make it to the hospital for morning rounds.

The hospital was now at level 4 storm readiness. Hospital preparations at this time included reporting of staffing plans and needs to the resource pool coordinator in the command center; notification to patients of storm status and preparation activities; relocation of emergency child care; distribution of supplies such as lanterns, flashlights, batteries, bottled water, linens, blankets, and personal cleaning supplies to staff; the transfer of respiratory therapy equipment to emergency electrical outlets; and the backup of electronic patient records and storage at an off-site location.

AUGUST 29: LANDFALL

Peak Census: 55; Midnight Census: 53

The daytime neonatology staff all made it into the hospital for rounds despite high winds and severe rain. During the morning, the first levee breach in New Orleans had occurred, and warnings of flooding were issued. We finished rounds at the usual time that afternoon with no requests for evacuations from New Orleans.

AUGUST 30: 1 DAY AFTER LANDFALL

Peak Census: 79; Midnight Census: 72

During the morning, a member of our group and 2 hospital vice presidents attended a briefing at the Louisiana OEP, which is located only 1 mile from the hospital. Although their plans for evacuation of infants at this time was transportation to level IIIB units in northern Louisiana cities that were 3 to 5 hours away from New Orleans, we requested that Woman's Hospital be designated as the regional transport center for pregnant women and infants. Our plan was approved as the flood-

ing worsened in New Orleans and evacuations were imminent. In conjunction with our hospital administration, we had determined previously that we could accommodate as many infant transfers as needed in the face of an immediate evacuation. We had recently opened our 30-bed special care unit, which uses a 3-patient-per-pinwheel design with a minimum patient footprint of 120 square feet per infant. Each patient space was duplicated and stocked with supplemental/rental equipment. Fortunately, the preexisting 20-bed special care nursery space had not yet been demolished and was reopened.

In the morning, we initiated communications with several of the NICUs in New Orleans to inquire about their status; all of them felt secure and that evacuations were not yet optimal or necessary. However, as the flooding intensified in New Orleans in the afternoon, we began to receive calls for evacuation. We mobilized 5 transport teams (1 lead NNP with a nurse or respiratory therapist as the second member) by ground to Alton Ochsner Foundation Hospital to transport 5 infants (see "Disaster Preparation and Lessons Learned at the Ochsner Foundation Hospital," pp S375–S380). Ground units were provided by our usual partner, Acadian Ambulance, a private company with 205 ground ambulances, 7 helicopter ambulances, and 4 fixed-wing aircraft based in southern Louisiana. The teams arrived back at the hospital at approximately 5:30 PM. As soon as the transported infants were brought into the nursery, the transport teams were dispatched again to New Orleans for the remaining infants at Ochsner Hospital. Because of the violence reported in New Orleans, some of which was directed against emergency personnel, it was felt to be necessary for the transport teams to be escorted by state troopers.

Additional neonatologists in the group had been called into the hospital to help with admissions. At approximately 7 PM, 16 evacuated infants from Memorial Medical Center began to arrive by helicopter (Fig 1). These infants were accompanied by 2 doctors who held and hand bagged the critical infants during the trip to safely facilitate a maximum number of patients (see "Caring for and Transporting Very Low Birth Weight Infants During a Disaster," pp S365–S368). Another doctor accompanied a patient by ground, and a nurse from the NICU accompanied each helicopter. The nonventilated patients were transported in their plastic bassinets (Fig 2). The last patient from Memorial Medical Center was admitted at 9:00 PM.

As with many of the evacuations, some infants' parents had not been notified of their infant's transport because of their own evacuations and lack of communication with the New Orleans health care providers. The process of establishing communication and ultimate reunion of infants and parents would become a daily priority for the health care team. The social services depart-



FIGURE 1
Evacuation of infants from University Hospital, September 2.



FIGURE 2
Newborns arriving in bassinets.

ment at Woman's Hospital undertook the coordination of information, which required 24/7 operation (see "Reuniting Fractured Families After a Disaster: The Role of the National Center for Missing & Exploited Children," pp S442–S445).

Our transport teams were still on the road at midnight.

AUGUST 31: 2 DAYS AFTER LANDFALL

Peak Census: 105; Midnight Census: 90

Nine new infants from Ochsner Hospital began arriving at approximately 1:00 AM. The rapidly growing census was associated with increasing duties for the staff, including the attending physicians. The "scheduled" on-call neonatologist assumed responsibilities for the existing patients, and additional neonatologists would cover the "new" patients. Shortly after the neonates from Ochsner Hospital were admitted, we were contacted by

someone at East Jefferson General Hospital requesting us to take in 10 evacuated infants. We grabbed a quick nap for a few hours before these new infants began arriving around 6:00 AM.

Our first priority each day was a team meeting of physicians and charge nurses to identify discharges and infants who could be transferred to other units when new evacuations occurred. I began calling other NICUs in the state to determine their bed capacity and ability to accept transfers should the need arise. Because we were the nearest level III regional NICU to New Orleans, it was logical to keep the sickest infants and transfer the less acute infants to the remaining units in the state. During rounds, we identified 9 infants to transfer to Earl K. Long Hospital, the charity hospital in Baton Rouge.

Before work rounds were completed, I was contacted by Children's Hospital of New Orleans to arrange transport for more NICU and PICU patients (see "Closing and Reopening of a Children's Hospital During a Disaster," pp S381–S385). The infants/children with cardiovascular disease were transported to Our Lady of the Lake (LOL) Children's Hospital in Baton Rouge accompanied by their cardiovascular surgeons. Two of the infants were in need of cardiovascular surgery: one would subsequently be transferred out of state for surgery, and the other would be kept stable until surgery could be arranged.

Obtaining ground units was becoming incredibly difficult at this time, because units, for the most part, had already been dispatched to New Orleans and were already overworked. Fortunately, some emergency medical technician units from other states had begun to arrive and were integrated into service. In addition, the level IIIB NICUs in Alexandria, Louisiana, were enlisted and were able to provide their own transport units, which was a great help. During the day, I received telephone calls from Kenner Regional Hospital requesting transport of 2 infants. When it was explained that there were no teams available, the transferring physicians brought the infants to Woman's Hospital in their own private cars. The majority of my day was spent on the telephone providing overall coordination to neonatal evacuations.

I had numerous visits to the OEP during the day. Although Woman's Hospital had been designated the referral center and given authority to arrange transports, it was still difficult to obtain ground units. The proof of verification of this authority had to be repeated daily by the OEP, which was one example of the frustrations we encountered from disrupted a communication chain during the evacuations.

By that evening, the National Disaster Medical System was in place. It was the general understanding among state officials that there remained approximately 2000 hospitalized patients in New Orleans who needed to be evacuated. Essentially, a field hospital was established at Louis Armstrong International Airport, where

evacuees would be triaged and flown to facilities out of state (see “The National Disaster Medical System Response: A Pediatric Perspective,” pp S405–S411). In discussions with OEP personnel, including Federal Emergency Management Agency and Louisiana State University (LSU) Charity Hospital officials, we were informed that no additional neonatal transports needed to be done from New Orleans because all neonates had been evacuated. Late at night, we welcomed this information, felt our job was manageable, and headed back to the hospital.

SEPTEMBER 1: 3 DAYS AFTER LANDFALL

Peak Census: 107; Midnight Census: 104

A Communication Breakdown

Without a doubt, this day marked the biggest day of frustration for me throughout the Katrina experience. More infants from Children’s Hospital of New Orleans began arriving at 1:30 AM with our transport teams. The teams kept returning to New Orleans for additional patients, with the final infant arriving at approximately 7 AM. In addition, 9 pediatric patients were being transported to OLOL Children’s Hospital, as was 1 infant who was born at a women’s shelter in Chalmette, Louisiana. Touro Infirmary needed to evacuate 14 level II infants. My previous telephone calls paid off, and 2 hospitals in Lafayette, Louisiana, had available beds and independently arranged for direct transfer of these patients.

A Communication Breakthrough

Incredibly, Cheryl Ory, RN, an NICU nurse at University Hospital, got a text message out to a friend in Colorado, who was able to get in contact with the president of the Louisiana Hospital Association. The University Hospital NICU was frantically caring for sick neonates in a facility without electricity, water, or supplies. Cheryl was desperately pleading for any kind of help, but mainly to get the neonates evacuated. I can remember looking at the people in the room with me in utter amazement, because we had been informed the previous night that there were no other neonatal evacuations that needed to be done. I was able to call Cheryl immediately to confirm the message I had been given and also to speak with Brian Barkemeyer, MD (see “The University Hospital NICU in the Midst of Hurricane Katrina: Caring for Children Without Power or Water,” pp S369–S374), who confirmed the presence of approximately 28 neonates at University Hospital. I, along with the Woman’s Hospital CEO and vice president for operations, immediately headed back to the OEP, where we sought out the CEO of the LSU Health Care Services Division. He confirmed the presence of neonates at University Hospital.

A preliminary evacuation plan for all patients at University Hospital to begin the next day was being circulated. However, because of the severity of conditions at

University Hospital, as stated to me by the NICU team, as well as our previous designation by the OEP for neonatal evacuation, we began working on a separate evacuation plan for the neonates. Although every official we spoke with was concerned because newborns were in danger, we made no real headway until obtaining the help of Major General Don T. Riley, Director of Civil Works, US Army Corps of Engineers, who happened to be related to one of our hospital administrators. As I would find out later from other pediatricians in New Orleans, evacuations often happened because of personal relationships and less as part of an organized evacuation.

With General Riley’s help, we were able to maneuver through the chaos and enlist the help of the Texas and Louisiana Wildlife and Fisheries Departments, as well as members of the US Army and Louisiana National Guard (Fig 3). As soon as these individuals were made aware of sick neonates still needing to be evacuated, it became their first priority. These were great people who wanted to help the infants. Unfortunately, because of the lateness of the day, we were unable to coordinate a transfer that evening. New Orleans remained without power, and the danger of attempting rescues in the dark was too great for all concerned. An alternate plan was devised, which entailed transporting infants by air boat (Louisiana and Texas Departments of Wildlife and Fisheries)



FIGURE 3
Evacuation of infants from University Hospital, September 2.

early in the morning to a landing zone for military helicopter pick up. The briefing for the mission was to be at 7 AM the next morning, and evacuation of the infants was to start at 9 AM. I briefed Dr Barkemeyer by telephone. All we could do was wait for the morning.

Meanwhile, care continued, although we were at double our usual census.

SEPTEMBER 2: 4 DAYS AFTER LANDFALL

Peak Census: 118; Midnight Census: 114

I was supposed to have received a telephone call that morning from the Department of Wildlife and Fisheries as to the status of the mission. When the call was not received, I went back to the OEP for an update. Things were delayed. The original LSU evacuation plan was back on. However, this plan entailed having the infants being taken to the airport and then subsequently airlifted out of Louisiana. I discussed this with those present, and we agreed on a new plan, with the infants being taken to the airport and then flown to Baton Rouge Airport by Acadian Ambulance. I notified the hospital that staff and members of the transport teams were going to be needed at the airport to triage infants until we could establish multiple ground units to move the infants to Woman's Hospital.

I then attempted to call Dr Barkemeyer about the new evacuation plans. When his cell phone was answered, I was informed by the person answering that he was on the roof of University Hospital evacuating infants onto helicopters. The cell phone eventually found its way to Dr Barkemeyer, who informed me that the infants were indeed being loaded onto helicopters as we spoke. I stressed to him that flight teams would be at the Louis Armstrong Airport to evacuate them to Baton Rouge and not to board the federal planes for out-of-state transfer. To this day, I am unaware of exactly which military unit evacuated these infants, but I am very grateful to those individuals who took it on themselves to rescue the infants.

At the time of my telephone conversation with Dr Barkemeyer, I was physically present with the military pilots in Baton Rouge who were supposed to have evacuated the infants. We all just looked at each other and shook our heads. We left the OEP to head to the airport. Because we were in our car, we could see the hospital in the distance with 2 Blackhawk helicopters approaching. Unbelievably, 29 infants (some with their mothers) from University Hospital were on the helicopters. Six of the most ill infants were kept at Woman's Hospital, 6 were sent to Women and Children's Hospital in Lake Charles, Louisiana, 13 to Earl K. Long Hospital, and 4 to Baton Rouge General, Bluebonnet.

There would be no more neonatal transports.

SEPTEMBER 3 and 4: 5 AND 6 DAYS AFTER LANDFALL

Peak Censuses: 125 and 114; Midnight Censuses: 114 and 101

We continued to triage patients to other facilities as well as home. One infant was flown back home to the Netherlands. Because the press requests were overwhelming, we instituted our "media times" at 10 AM and 4 PM daily for the next 2 weeks.

The CEO of Woman's Hospital and I met with Rich McKeown (HHS Chief of Staff, US Department of Health and Human Services) and Mark McClellan, MD, PhD (Administrator, Centers for Medicare and Medicaid Services) to discuss the role of the private sector in hurricane relief. Also in attendance was the Chancellor of LSU Health Care Services, Louisiana Hospital Association representatives, and a member of the US Surgeon General's office. After reporting on the current status of the hospitals in Baton Rouge, we cautioned them that we expected a surge in Medicaid patients and that Louisiana, like many other states, has inadequate reimbursement for pediatric services.³ We felt that it was extremely important to obtain some assistance for the private providers in Louisiana who provide the overwhelming majority of services to the state's Medicaid population and would move us closer to compliance with the American Academy of Pediatrics policy statement on Medicaid reimbursement.⁴ We expected this to increase with the closure of the Charity Hospitals in New Orleans. We were trying to rid the system of financial barriers in obtaining pediatric care. (As of submission time, instead of relief, Medicaid Current Procedural Terminology code reimbursement was cut for pediatricians [see "Children's Hospitals Meeting the Challenge Together," pp S357–S358].)

SEPTEMBER 5 (LABOR DAY): 7 DAYS AFTER LANDFALL

Peak Census: 104; Midnight Census: 97

Our census remained high but was beginning to decrease, at times to below 100. The neonatologist schedule was moved back to our usual 4 rounding attending physicians during the day plus 1 NNP. We also began to receive offers from other NICUs across the country to transfer infants whose parents were relocating to their area as well as offering to send staff. In some cases, the hospitals were even willing to take families and help them relocate. The benevolence of the health care sector was refreshing and much appreciated.

In my opinion, the most significant outcome for the children of Baton Rouge occurred on this day. Representatives from the OLOL Hospital and Primary Care Physician Network and I had multiple discussions regarding pediatric care for Medicaid patients in our city. Although some pediatricians in our area accepted Medicaid, there still remained approximately 1300 infants born at our hospital who entered the charity hospital system on a yearly basis. Although we had previously

reached a general consensus on how care would be provided, a decision was made that all children on Medicaid could be cared for in the private sector through OLOL Children's Hospital and Primary Care Physicians. This agreement ensures that all of the children born at Woman's Hospital would have their own pediatrician. This was done without the promise of increased reimbursement by the Louisiana Department of Health and Hospitals or other sources. The end result was a private solution to a public problem in our city. Indeed, something good had come out of the storm.

SEPTEMBER 6 THROUGH 19: 8 TO 21 DAYS AFTER LANDFALL

Peak Censuses: 97 and 98; Midnight Censuses: 95 and 92

The next 2 weeks quickly settled into a more normal routine. The social service department generated daily lists of the location of patients' parents and daily assessments of parents' relocation areas. For the remaining hospitalized patients, transfers were initiated when the infants were stable and based on their parents' locations. Infants were transferred to Toledo, Ohio, and Atlanta, Georgia, to be with their parents. Our last infant to be reunited with his parents occurred on Friday, September 9, 11 days after the hurricane.

SEPTEMBER 22: 24 DAYS AFTER LANDFALL

Peak Census: 106; Midnight Census: 101

A warning for Tropical Storm Rita was issued in our area. We received 13 infants from Lake Charles by helicopter. Four ground-transport teams in a convoy brought more stable infants with police escort. Thankfully, the escort was only needed for traffic this time. Some of the infants we received were infants first transported to Lake Charles from Woman's Hospital during Hurricane Katrina. A military Blackhawk helicopter was secured to bring infants from Lafayette to a safer location in Baton Rouge.

SEPTEMBER 23: 25 DAYS AFTER LANDFALL

Peak Census: 104; Midnight Census: 99

I attended a meeting with the LSU Department of Pediatrics faculty regarding initiation of resident training in the NICU at Woman's Hospital. The teaching facilities in New Orleans had been heavily damaged, and providers throughout Baton Rouge had been asked to assist in resident training. Our meetings would eventually culminate in a second-year/third-year resident rotation for 2 to 3 residents per month in the NICU.

Since the hurricanes, most of the infants have been discharged or transferred nearer to their families at children's hospitals in Fort Worth, Houston, Lubbock, Galveston, and Austin, Texas, and Salt Lake City, Utah. The reimbursement for these transports was arranged through the National Center for Missing and Exploited

Children (see "Reuniting Fractured Families After a Disaster: The Role of the National Center for Missing & Exploited Children," pp S442-S445) and the Federal Emergency Management Agency.

COMMENTS AND LESSONS LEARNED

Without question, the key to our successful evacuations and provision of care for neonates from New Orleans was the Woman's Hospital administration's preparations for such a disaster. The hours spent by administration and medical staff in preparing and implementing standards and procedures at our hospital were well rewarded during Hurricanes Katrina and Rita. The presence of a crisis-response team is of the utmost importance. An established, published chain of command and responsibilities was invaluable during the evacuations.

Preparing for the surge in capacity for hospitalized children in any geographic area during a disaster is a problem. Coordination of facilities and personnel responsible for the mass evacuation of children needs to be established at the city, regional, state, and interstate level. In the case of Louisiana, this did not exist. Any type of disaster, natural or man made in any part of the country, can inflict the same effects on a city/region as did these hurricanes. A list of pediatric facilities, providers, and modes of transport as well as evacuation routes must be included in any disaster/evacuation plan. Although these plans may exist for an individual hospital, it is unlikely to be pediatric-specific. The relocation of major services such as cardiovascular surgery, extracorporeal membrane oxygenation, critical care units, and teaching programs should be included in any disaster plan.

Shelters for children and their families must be part of this plan also. As we discovered during the hurricanes, shelters do not usually accept pregnant women after 34 weeks' gestation because of the risk of delivery at the shelter, and shelters oftentimes do not have facilities for even normal newborns.

There should be several people in each state capable of serving as the overall coordinator in a crisis, and a regional plan that determines which coordinator is in charge should be established during crisis planning. During a disaster, daily calls to participating centers to assess census and capabilities should be made. These calls should originate from the overall coordinator.

The biggest obstacle in many cases during the hurricanes was communication, both hospital to hospital and hospital to parent. Landlines and cell phones can be disrupted easily. Alternative communications such as satellite phones, HEAR radio, and a NORAC system must be in place. This type of disaster planning should not be left for elected officials to do alone, because the expertise needed will not exist without the input of pediatricians. It is up to each of us in our own community to ensure

that this happens. The American Academy of Pediatrics can be instrumental in undertaking this task.

There will be a great impact on the staff of a hospital who, as in the case of Woman's Hospital, are the recipients of evacuees. While caring for patients, each staff will probably also have concerns of a personal nature. Obvious areas identified during this disaster were issues such as day care for children of working health care providers, the extra hours that providers were requested to work because of patient volumes, and the disruption of daily routines. The most important issue to be considered is time for staff to rest and recuperate, including physician caregivers. Our group quickly instituted a work schedule for ourselves, because we knew our patient census would remain elevated for a prolonged period of time.

In the first 4 weeks after Hurricane Katrina, Woman's Hospital experienced more than 100 media encounters with local, national, and international radio, newspapers, magazines, and television broadcasts. Dissemination of information during a disaster for the news media as well as family members and governmental officials is important. Accurate information is paramount to dispelling rumors during a crisis. For medical issues, a single physician spokesman should be appointed. In our case, I assumed this role, as well as the role of logistics officer. The time required for the roles may be full-time, as I

experienced during the first week of the evacuations. It is important to use preexisting personnel, such as the hospital public relations department, to help with this issue. In this experience, all of the media requests were funneled to 1 person in this department who then enlisted me as needed. The use of press conferences allowed me to function in other duties.

CONCLUSIONS

It will be incumbent on each of us in our own environment to be responsible for the care of children in times of crisis. Hopefully, the wake-up call issued to Louisiana will be heeded by pediatricians everywhere and some of the mishaps during these events can be avoided in the future.

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