Lessons from Hurricane Katrina: One HIM Director's Experience

by Mark Hagland

How can an organization protect patient information during a disaster? Perhaps the most dramatic real-life example in recent years was Hurricane Katrina, which struck New Orleans in August 2005. The experience of the HIM professionals at West Jefferson Medical Center in Marrero, just across the Mississippi River from New Orleans, shows that it is possible to safeguard patient privacy and security while working in a tenuous and very stressful operating environment.

Preparing as much as possible, having policies and specific contingency plans in place, and managing intelligently in the moment were vital to the success of patient care operations and HIM in the wake of Katrina, says Indra D. Osi, RHIA, CHP, director of health information management at the 451-bed center, situated just 10 minutes from downtown New Orleans. "It can be done," she says, "though we certainly did learn lessons from the experience."

Dry, but Not Cool

Osi was born in New Orleans but grew up mostly in California. As such, she had zero personal experience with hurricanes. Still, when West Jefferson executives called her and other staff designated as essential to come in to work as the hurricane approached New Orleans, Osi loaded up her car and drove to the hospital prepared for a long siege, which ultimately turned out to be 21 days.

Osi and her colleagues were in the hospital when Katrina passed over, and though the hospital and its neighborhood were spared direct flooding, they were faced with a series of challenges and hardships. They lost electrical power (including air conditioning), running water (through an electrically pumped water system), and outgoing telephone service (after the storm, incoming calls could be received, but outgoing calls could not be placed).

After electricity and the ability to pump water went out in the early morning hours of Monday, August 29, "We filled trash cans with water for washing and turned to bottled water for drinking," Osi recalls. "Our plant engineers were wonderful; they found generators from somewhere and hooked them up and were able to give us electricity enough to run the lights and the overhead paging system," as well as the fans to cool the patients, who were sweltering in 100-degree heat. Osi and her colleagues worked in very difficult conditions for 36 hours before electricity and some other services were restored.

Within the HIM department, four HIM professionals had been designated as essential and were on duty, including Osi. Two other HIM professionals reported for duty, but since available resources such as beds were stretched (staff were living in the hospital), those two were released to try to find their families after the first day. Looting had begun, and the personal safety of the staff as well as patients coming from the city was a major concern.

"We tended to patients as we could," Osi says, noting that within a few days, the federal government had set up a disaster management assistance team (DMAT) on the hospital's front lawn, similar to a MASH unit, to triage incoming patients. Fortunately, the hospital was not overwhelmed with new patients, but staff had their hands full taking care of patients in an environment of limited resources.

With Power out, Turning to Paper

On the HIM side, Osi and her colleagues dealt with an interesting situation. Several months before Hurricane Katrina hit, the hospital had gone live with an electronic health record (EHR) system. "Our plan for the EHR had been to retain hard copies of documents for the first six months, as well as of everything that was being scanned into the system or cold-fed; and after that we would destroy the paper," Osi says.

The medical center had not begun destroying hard-copy records when the hurricane hit, Osi notes, "So everything was being maintained in a storage facility on the East Bank of the Mississippi River, and none of those records were damaged. But everyone had evacuated the East Bank," she says, and none of the records were available. Consequently, hospital staff had access only to records beginning January 1 of that year.

In addition, "In preparation for a hurricane, we had indicated in our disaster planning that if we were to lose electricity, we would use our printed discharge logs to locate patient records, and we were able to do that successfully by interviewing patients." As a result, HIM created paper records for patients, and, Osi says, "Everything was ready to go when the electricity came back on and they were able to power up the computer systems." Handwritten physician notes were then transcribed into the EHR by off-site transcriptionists. That aspect of handling the emergency worked fine, she says.

Emergency Record Release Protocols

The HIM department received about 100 requests for patient records, and Osi explains that she and her staff followed emergency standards for record release indicated by federal HIPAA regulations. "We only honored requests from physicians and hospitals and not from insurance companies," she explains. "We told the health insurers they would have to wait until after the crisis.

Meanwhile, we knew that the requests we were getting over the phone from doctors and hospitals were legitimate. But we documented the identifying information that the requesters provided us, and asked them to follow up by sending a fax on their organizational letterhead; we also tried to do as much due diligence as possible on our end. We documented the person's name, telephone number, fax number, full name of the facility, and reason for the request, and then faxed the information to them; and we had a cover sheet that had a fax receipt confirmation form on it for them to fax back to us."

Fortunately, Osi continues, she and her colleagues at West Jefferson were never pressured to release original hard copies of patient records. Some downtown hospitals sent patient records out with patients being evacuated on helicopters, but West Jefferson HIM staff had time to plan for transfers and make copies of paper records. Meanwhile, very few requests from families for identifying and locating patients came in, partly because West Jefferson was not one of the major places to which people were relocated. On another identification front, the small number of volunteer physicians and other clinicians who showed up unannounced for duty were referred to the DMAT for verification of their credentials.

Lessons Learned

A number of lessons learned are clear to Osi from the Katrina experience, she says. While West Jefferson had done a good deal of disaster planning in advance, the actual experience of a hurricane disaster and its aftermath helped crystallize everyone's thinking. "The number-one thing we should have had," Osi considers, "was an electronic means to access our master patient index, even though our systems would be down.

"I had asked for a backup to our EHR in the event of a loss of power, prior to Katrina, in order to be able to manually access patient information-which is what we ended up doing in this case. But I had been told that if we were to undergo a situation so catastrophic, we wouldn't be at the facility. That turned out not to be the case in this circumstance. Since the hurricane," she reports, "IT has created a redundant electronic site in San Antonio, Texas."

A second major lesson learned, Osi says, is that "You need to develop a way to keep in touch with your staff if they're scattered around the country. You want to educate your staff about the need to stay in touch, what information they need to provide you, like emergency contacts; and you need to instruct them on how to contact you or the facility for instructions about when to return to work, about what facilities, plans, support, have been set up for them-in other words, to train them comprehensively on how to respond in a disaster." And, she adds, HIM leaders must make absolutely sure that all the contingency planning being done must clearly address potential contingencies that could face the HIM department itself.

Finally, she says, a lesson for the entire nation and for all types of natural disasters is that "What's very clear is that there has to be a central database that can address the need for appropriate clinical information sharing. With proper authorization, people could access their patient records" even in severe emergencies like Katrina, she notes. "One of the failures of Katrina that has been cited was lack of a uniform, universally accessible electronic medical record."

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