I. PREMISE

It appears that Maine is enduring a quiet crisis in health care—generally very good quality, but an extreme outlier among the States with respect to cost, and therefore, affordability and accessibility. This cannot be a proposition that is sustainable in the long-term. I know from personal experience in the utility industry the consequences of excessive, uncompetitive costs which are often mandated or tolerated by well intentioned public policies, when they reach a level that is indigestible to the market and suddenly become “stranded costs.”

Moreover, this market pressure will be accompanied by a further squeeze from governments themselves as health care cost escalation sucks much of the incremental growth out of tax revenues, to the detriment of the educational systems and the requirements of general government.

It is not my job to propose how to manage health care cost escalation here in Maine. Although I am confident part of the answer will come from rigorously pursuing the work in quantifying, comparing and benchmarking cost and quality performance for medical care pioneered by Dr. Daniel Hanley here at Bowdoin. I firmly believe that such comparative work is the first building block in managing any problem in complex organizations, including businesses, governments and health delivery systems.

What I do want to discuss this evening is one of the great crises of our time, Hurricane Katrina, and what lessons it may offer us for how to manage at least emergency responses in the health care arena, and perhaps even the more fundamental crisis of balancing quality, cost and access.

II. THE SIGNIFICANCE OF KATRINA.

A. SCOPE OF DISASTER

Hurricane Katrina was an enormous national trauma—the biggest disaster since 9/11. In part because of the initial damage-sweeping over an area the size of Great Britain (90,000 square miles) and slamming into a coastline equivalent in length to the distance from Boston to Bar Harbor, destroying much of one of America’s most beloved cities, and killing 1,500 human beings.

But even more because of sluggish, uninformed and often incoherent response of governments at all levels to the crisis.

Who can forget the abandoned, flooded school buses? Or the suffocating squalor of the Superdome? The arsonists, looters and shooters running wild on the streets? Or the Director of FEMA on national TV, clueless as to existence of the ad hoc shelter for thousands at the New Orleans Convention Center? Or the Secretary of Homeland Security flying off to a conference as the city sank beneath the waves? It was grotesque,
B. SCOPE OF INVESTIGATION.

Sen. Collins chaired the Senate Homeland Security Committee and soon after the storm subsided, secured a Senate resolution authorizing an investigation. Now I know the true meaning of the phrase “making a federal case out of it.” I served as General Counsel for the Investigation. We conducted some 300 interviews under oath, organized 23 Senate hearings, reviewed 800,000 pages of documents and wrote a 750 page report, which in turn led to the enactment of a federal law last September making substantial reforms in the federal disaster response system. All was done on a bi-partisan basis under the leadership of Senators Collins and Lieberman.

C. FINDINGS.

Our investigation found that the management of the response to Katrina was crippled by a combination of:
- poor planning and preparedness;
- poor communications- in both durability and interoperability;
- poor “situational awareness” on the part of responsible authorities;
- inadequate coordination of search and rescue operations;
- grossly delayed evacuation of stranded victims;
- inability to provide medical services when and where the needs were most acute;
- inability to deliver sufficient food, water, sanitation or other commodities;
- a breakdown in public safety;
- “uncertain” coordination among various military units; and
- deficiencies in the National Response Plan…among other things.

That’s a complicated litany of troubles, and I want to try to get to root causes right away.

III. WHY DID WE FAIL?

In the richest country in the world, with the best infrastructure, the most powerful military, most extensive communications network-newly refocused by the recognition of the need for homeland security by 9/11-why did we do so poorly in responding to Katrina?

In sector after sector, very similar patterns emerged:

A. FAILURE TO PLAN sufficiently and to address the really difficult issues, like…”how exactly do we evacuate the poor, sick and elderly without their own cars, let alone tourists?”
B. FAILURE TO EXERCISE with actual leaders and plausible scenarios among different levels of government and different sectors.
C. FAILURES OF COMMUNICATIONS—the power of the storm destroyed radio towers and phone lines and left the region virtually voiceless for days-sabotaging most efforts to coordinate forces and build a big picture situational awareness for crisis managers.
D. POOR ORGANIZATIONAL DESIGN that cramped the purpose and capabilities of FEMA, and created conflict and uncertainty in state and federal agencies with overlapping responsibilities, and brought to mind for our investigators the fiasco of Desert One—the failed Iranian hostage rescue mission, ruined by uncoordinated, incompatible standards and practices of the various military units involved. And, above all,

E. In all too many cases, FAILED LEADERSHIP. Here I want to emphasize this was a largely collaborative effort by the ranking Majority and Minority leaders of the Committee, Collins and Lieberman, with clear instructions to their staffs, to really get at the truth of what happened, and not to criticize people for the sake of partisan advantage, but also not to hold back where necessary to point out some shortcoming in our system that needed to be addressed. The observations I make here tonight are my own responsibility, but they are made in that spirit. I will focus on leadership for the rest of this discussion.

IV. THE ROLE OF LEADERSHIP IN CRISIS RESPONSE.

Crisis leaders face a number of daunting challenges, which grow exponentially with the scope of the problem, and must, also, carry out a number of critical functions, including:

A. UNDERSTANDING THE PROBLEM. The leadership should understand as best it can what the nature of the problem is, its root cause and what harm it is creating. The common parlance for this these days is “situational awareness.” Good leaders will be asking timely probing and penetrating questions of eyewitnesses and experts in the effort to find out what’s happening.

B. PROVIDING MORAL LEADERSHIP. A supremely important need is for the crisis leaders to give hope and reassurance to the victims that the rest of the nation cares about them and is doing all they can to help. A striking example was Lyndon Johnson coming to New Orleans the very next day after Hurricane Betsy struck in 1965, providing a hands-on, visible form of support even if there was little tangibly he could do, but it was a prerequisite for mobilizing public support for relief efforts and Congressional appropriations. In other cases, the leader will be literally rallying his forces to go into dangerous situations, or persuading citizens to leave their homes, pets and treasures, or promoting the public sacrifices necessary to achieve a resolution.

C. PROVIDING OPERATIONAL LEADERSHIP. Declaring the state of emergency, selecting appropriate managers, monitoring intelligence reports, and standing up the inter-agency emergency operations centers are among the first critical tasks.

D. FINALLY, PROVIDING LOGISTICAL LEADERSHIP. Maybe not so sexy, but absolutely essential.

( 1.) UNDERSTANDING WHAT GOODS, SERVICES, FORCES AND OTHER RESOURCES ARE NEEDED to stop the cause of the harm, protect the victims, alleviate the suffering and begin the rebuilding process for the community.
(2) KNOWING WHERE TO FIND THOSE RESOURCES and how to effectively procure them, coordinating requests so as to avoid duplications in some, while leaving gaps with respect to others, and (3) TRACKING AND DELIVERING the appropriate resources in appropriate quantities in a timely manner to the points of greatest need. Certainly in Katrina great problems arose because FEMA had little idea where its chartered trucks ever were—leading to such spectacles as the delivery of truckloads of ice to Phoenix and Portland, and giant stockpiles building up within New Orleans while a few miles away thousands starved on exposed Interstate overpasses.

All these responsibilities call for leaders with vision, knowledge, and an ability to both work with others in complex, even extreme, circumstances, and to make unambiguous choices decisively.

V. THE IMPORTANCE OF COLLABORATION.

A. NIMS. Such is the complexity of the three-dimensional chessboard of catastrophic crisis management that collaboration among disparate agencies, sectors and levels of government, NGO and private responders that the National Response Plan is structured upon a collaborative model known as the National Incident Management System (NIMS), which in turn is based upon a model first developed by the State of California and the US Forest Service for fighting multi-jurisdictional forest fires. NIMS is a common sense template that calls for a joint operations center for all the relevant agencies, with leadership based on a hierarchy of recognized qualifications and credentials, pursuing a common strategy with joint operations.

B. FAILURE TO COLLABORATE EFFECTIVELY A ROOT CAUSE OF FAILURE IN KATRINA. In our Report, we concluded “If the incident is a disaster or catastrophe, the failure to coordinate multiple agencies from different jurisdictions, each with its own internal lines of communication and authority, can seriously degrade the capabilities of the government as a whole to respond effectively. The absence of interoperable communications or an effectively trained and exercised plan will further undermine the response.” (p.558) What makes this approach as challenging as it is necessary is that it requires an advance understanding of the approach, mutual respect for the credentials of other participants, and arriving at a strategy, not by fiat, but by agreement, often very quickly and with incomplete information.

C. EXAMPLES OF WHAT WENT WRONG WITHOUT SUCH COLLABORATION.

(1) SEARCH AND RESCUE. This truly is a matter of life and death. Rescue operations by the USCG, Louisiana Wildlife and Fisheries, the military and others were truly heroic. But we found “The lack of coordination had several significant consequences. Agencies searched areas without knowing whether those areas had already been searched by others. The agencies in boats were mostly unable to coordinate with the NG or USCG to request helicopters if victims needed to be airlifted. Finally, the
lack of coordination prevented food, water, and other critical needs from reaching the rescuees gathered at SAR collections sites.” (p.336)

(2) PROCUREMENT. Another egregious failure with vast consequences was the inability, for 2 weeks, to set up a joint resources request mechanism. The Federal Coordinating Officer for Louisiana testified that “People down there were asking everybody for everything so when the final analysis is done, and everybody gets all the records of who asked who when, there’s a tremendous amount of duplication and there’s a tremendous amount of gaps.” (p.562)

(3) MEDICAL CARE. Other examples are rampant through every sector, but you might be particularly interested in some of the failures of collaboration in the health sector.

(a) SPLIT JURISDICTION. Louisiana has both public and private hospitals, and a State Department of Health and Hospitals. Instead of choosing a single agency to head up response efforts or to form some kind of coordinating council, the State emergency plan split the responsibility between DHHS, which was given responsibility for public health, sanitation and special needs patients; and the LSU Heath Sciences Center, which was made responsible for not only for finding alternative shelter and care for public hospitals patients and some nursing home patients, but also for coordinating the planning and actions of the private hospitals in an emergency.

Can you sense what’s coming next?

Dr. James Aiken of LSU testified “Oh, I understand the confusion because we are not doing it the way-exactly the way- the Emergency Operations Plan…LSU actually does not coordinate the overall hospital response…What you see in the plan is not what actually happens…I don’t know of any substantial act of involvement that LSU has on nursing home and home-health patients.”

We concluded that as a result of LSU’s failure, there was inadequate attention to emergency planning for important components of the health care system in Louisiana.” (pp.407-8) Not the least of the collateral damage from this failure was the exclusion of any direct representation of the plight of the nursing homes from the Emergency Operations Center. Ambiguity as to responsibility, lack of accountability, and failure to collaborate all conspired to undermine efforts to protect some of our most vulnerable citizens.

(b) LACK OF COMMAND AND CONTROL. A truly painful example of failure to establish leadership through consultation, prioritization and collaboration was presented by the Disaster Medical Assistance Teams (DMAT), FEMA’s first strike medical relief capability…presumably.

At the time of Katrina there were 52 DMAT teams of which 25 were considered fully operational, and at least 9 were dispatched to the devastated area. But they lacked administrative support, communications or integration with any kind of overall command, so that only one actually made it to the scene before the Hurricane hit, and when they did get in they were often deployed hundreds of miles from where the needs were most acute, and sometimes without their supply trucks, and without the ability to communicate even with the NDMS leadership in Baton Rouge. (pp.412-3)

As a result of these deficiencies at least two spectacularly bad things happened:

(i) At the Superdome, the Oklahoma team became concerned that the security conditions were deteriorating so much, that they left. They left, with all their gear, all
their medical supplies, all their charts and records…and they didn’t tell anybody they were going! Not their own leaders, not the National Guard officers in charge at the Superdome, not the military doctors left behind.

When another DMAT team ultimately replaced the departers, Gen. Gary Jones of the LaNG testified, “I said, are you going to stay this time? And they said ‘Oh, yeah, we’re going to stay.” And I said ‘Well, that’s good, because I would hate to have to shoot somebody.” And they laughed and said ‘You’re joking. Obviously, I mean, I wasn’t going to shoot anybody. But I kind of voiced my displeasure with the fact they had left me unsupported.” (p.406)

This is NOT a collaborative model.

(ii) Another terrible problem arose at Louis Armstrong International Airport, which had become without any planning, a de facto field hospital because SAR personnel brought victims with medical needs there in hopes of air transport out. Here the problem was that the number of patients ballooned to more than 4,000 in just a few days, creating what one NDMS doctor called “the hospital from Hell.” While the 3 DMAT teams on site worked tirelessly and heroically in desperate circumstances, for the first 2 and ½ days they received no relief or reinforcement from others –while other teams remained undeployed or underutilized. (p.412)

C. CREDENTIALING. Not so dramatic as the DMAT saga, but destructive to the smooth operation of a collaborative system was the chaos caused by the lack of a uniform credentialing system where people could understand the relative skill and experience levels of others with whom they were dealing for the first time. We found “Any significant medical or public health response will require that health-care personnel move across localities and states to assist in meeting …surge needs…” However despite a 2002 law mandating creation of a federal system, DHHS had not put such a program in place when Katrina hit in 2005. As a result, in the emergency the government called on a private contractor to sort out the credentials of the 34,000 volunteer medical personnel who signed up, of whom only 1,400 actually deployed in the Gulf States. Creating this massive federal checking effort took enormous time and resources and experienced many problems, resulting in an ultimately haphazard and inefficient program to harness the skills offered in this great outpouring of generosity from the medical professions. (p.417)

Believe me, I could go on, for in the health sector alone there are many more examples of serious failures and shortcomings, but I think you get the picture. And I do want to speak to some examples of personal leadership before I conclude.

VI. EXAMPLES OF EFFECTIVE LEADERSHIP: WHAT WORKED.

There WERE actors in this drama who DID demonstrate effective leadership–they were not uniform in style, for sure–there is no cookbook I am aware of with a sure-fire formula for success, but some people did make a major difference in the conduct and management of the response to Katrina.

A. THE US COAST GUARD LEADERSHIP TEAM.
This group of officers moved their planes out of the storm zone in advance, developed a plan to come back as soon as the storm subsided, backed up by planes and helicopters from other CG districts, and on their own initiative began SAR operations as soon as the winds dropped low enough to allow them to fly. They rescued over 33,000 people in the first week. (p.333)

Why did the CG stand out? We concluded it was because they developed a plan in advance; they constantly exercise, and practice on smaller but still real emergencies; there is a tradition and expectation of individual initiative; the CG was an early adopter of the NIMS approach to crisis management, as well as having an effective command and control structure; it had its own communications system; and long years of work in the District gave rise to a close familiarity with the governments, values and geography of the region.

B. GOV. HALEY BARBOUR OF MISSISSIPPI.

Katrina was every bit as catastrophic for coastal Mississippi as it was for Louisiana. Indeed, Mississippi suffered more deaths as a percentage of the exposed population. And many things went wrong there.

But Mississippi was able to establish an effective Emergency Operations Center and reestablish limited communications and begin relief efforts earlier and more effectively than Louisiana.

In part that was due to some extraordinary assistance from the State of Florida, which released its own hurricane-ready resources to its near neighbor.

And Mississippi seemed to have an easier time of it dealing with the federal government. That may be due in part to the appointment of William Carwile, one of FEMA’s most experienced and capable managers to serve as the Federal Coordinator there. His Mississippi counterpart, the Director of MEMA, credited their success to “being joined at the hip with Carwile” from 2 days before landfall and the “extensive prior training they had had in the Incident Command System.” (p564)

But it was unquestionably also due to the leadership of Gov. Barbour, who took command of the situation, assembling a joint EOC staffed by his ESF leaders in a collaborative working relationship with Mr. Carwile and establishing clear lines of authority, including State authority to require the evacuation of hospitals and nursing homes. (p.410)

All was not peaches and cream, and the Governor refused to allow regular military forces into the State for fear of splitting or losing his authority as commander in chief of the operation, and the head of the US Public Health Service established a separate headquarters apparently because of her disagreements with Mr. Carwile.

But by and large, the Governor’s insistence on intelligence, prioritization of reestablishing communications, state/federal collaboration and decisive executive leadership worked well for Mississippi.

C. LT. GEN. RUSSELL HONORE

Gen. Honore was commanding officer of the US First Army, headquartered at Ft. Benning, Georgia. He was an unlikely candidate for collaborative leader of the year. He
had the persona of Gen. Patton, tough-talking, hard driving, with a cigar firmly clamped in his jaw.

But he was a Louisiana native, and as soon as he perceived the trouble his home state was in he headed over on his own initiative, without an army to follow him or an order from above to legitimize his mission, in part because the Joint Forces Command at the Pentagon did not want to even receive his request to deploy military assistance until after the hurricane had made landfall and FEMA had asked for DOD help! (pp. 478-9)

Nevertheless, his critical function was to, at long last, organize the bus evacuation of survivors from the insufferable conditions of the Superdome and Convention Center. A lot of other people contributed to this result, and it would have happened eventually anyway, but Gen. Honore can take credit for getting it to happen as soon as possible under the circumstances that existed when he got there. More over, his brave talk gave people hope that at last help WAS on its way, and helped mobilize and energize soldiers and civilians alike.

But interestingly, for all his bravura, Lt. Gen. Honore always deferred to the top officer legally in command, LaNG Maj. Gen. Bennett Landreneau, and worked cooperatively to help him achieve his objectives in utilizing the military forces available. Indeed, it was a combination of regular army officers and local Guardsmen who ultimately effected the salvation of the victims in the city. (pp.364-5)

His initiative, his vision of what would be needed, his collaboration with officers outside his command, and his encouragement to the people of the region all warrant his special recognition.

D. ADMIRAL THAD ALLEN, USCG.

A week into the disaster, Adm. Allen succeeded the discredited FEMA Director, Michael Brown, as the “Principal Federal Officer” on the scene. Under the version of the NRP then in effect, the PFO had no legal authority to command anybody—he was kind of a coordinator, and spokesman and conduit back to Washington for information. However, Adm. Allen, well versed in NIMS, quickly took over leadership of the entire operation, established an effective Joint Field Office with Louisiana officials, helped develop a common set of priorities and began bringing order out of chaos. (p.564)

VII. EXAMPLES OF FAILED LEADERSHIP: WHAT DOESN’T WORK.

Time does not permit a thorough analysis of this topic. Suffice it to say that effective leadership was the exception, not the rule, in Katrina. Let me give you a few quick examples:

A. MICHAEL BROWN—the FEMA Director at the top of any list—he was insubordinate to his boss, uncommunicative with respect to critical information he’d gotten from the field, failed to follow through on commitments to get buses he’d made to Gov. Blanco, focused on his public image instead of the job, resentful he’d been sent to the field by the Secretary, contemptuous of the local leadership, and generally the paradigm of a poor leader himself.

B. MICHAEL CHERTOFF—the Secretary of Homeland Security—is a very intelligent, dedicated individual. But in this crisis he proved to be remote, out of touch
with his own Operations Center at critical times, reliant on the disloyal Brown, I believe
lacking in collegiality with either Governors and Mayors, his own staff or other cabinet
members, and indecisive on “leaning forward” with pre-storm help and invocation of the
catastrophic annex to the NRP. If Gen. Honore was a master of rallying the community,
Sec. Chertoff was the opposite.

C. GOV. KATHLEEN BLANCO, the Governor of Louisiana, was inconsistent,
unsure of her priorities, tolerated a chaotic EOC, and lacked an understanding of the
importance of planning, for example exonerating her Secretary of Transportation for
failing to come up with a mass evacuation plan as just a “paperwork glitch.”

D. DR. FRED CERISE-a name few have heard, and I only bring up as a cautionary
tale for the medical community. He was Secretary of Louisiana’s DHHS as well as a
physician. His reaction to the disaster was to courageously go to New Orleans to offer
his personal medical services, and he took part in several harrowing rescues of hospital
patients down there. But he was isolated, with virtually no communications possible with
any other unit and thus was unable to carry out his primary responsibility of providing
guidance and leadership to the entire Department and the ESF-8 function overall. He
effectively abdicated by setting out on his humanitarian mission.

Again, I think you can see common patterns with respect to the absence of
communications, consultation and collaboration that characterized several of these
unsuccessful leaders.

VIII. LESSONS FOR THE FUTURE

A. RECOMMENDATIONS.

We tried to distill our report into a series of 87 separate recommendations,
addressing a wide range of problems, from the lack of a regional structure in our
emergency response organizations, to funds for more interoperable communications to
training to making the federal government more “pro-active” in the face of impending
disaster. (pp.607-30) Much of what we proposed has actually been enacted into law.

But in my judgment, the heart and soul of our disaster response capability will
remain in the commitment of leaders, professionals and volunteers to plan, to exercise, to
communicate and to form common strategies and priorities for addressing whatever
challenges we face. We don’t need a common leadership style, or to clone some special
type of personality. But we do need recognition we’re in this together, and we are far
more likely to work our way through whatever it is if we do so collaboratively.

B. CONSIDERING MAINE.

You are an appropriate group to think about whether we here in Maine have a
realistic, implementable ESF-8 plan to provide health care assistance in the event of a
major disaster, especially in that critical first few days before federal help may become
available.

1. Do we have genuinely cooperative plans among health care providers of all
types and locations?
2. Do we exercise with actual leaders present considering realistic scenarios?
3. Do you all have a clear understanding of the jurisdictions of the Maine State Police,
CDC and MEMA? Is it a workable division of command? Do you know who will be representing you at the EOC?

4. Do you have interoperable communication systems with those agencies and each other?

5. Can our State mobilize and coordinate the resources of 38 hospitals, more than 100 ambulance companies, and thousands of doctors and nurses, EMTs and paramedics to quickly address serious mass casualty events?

6. Do you have a common understanding of what medical supplies and resources may be available, their location, configuration, and packaging and a plan for getting them to your area?

7. Have you established a practice of collaboration and consultation among yourselves and with other sector leaders to consider emergency contingency planning?

Every State is different, for sure, but the trauma in Louisiana and Mississippi shows how very difficult this kind of work really is.

You have a lot on your plates, I know, including the insidious cost issues I raised at the outset. But the fact that we live a thousand miles from the primary hurricane zone is no reason for complacency—whether our next disaster is a plane crash, or a widespread illness, or, God forbid, a terrorist attack somewhere in the region that sends panicked refugees our way, in our wonderful 21st Century world, I am afraid emergency planning is a serious, urgent priority for all of you.

Good luck.