Teaching Note
Collaboration amid Crisis: The Department of Defense during Hurricane Katrina*

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The case concentrates on the relationship between FEMA, the chief coordinator of federal efforts to respond to Hurricane Katrina, and the most powerful, single actor that FEMA can call upon, the DOD. It is worth noting that the goal of the case is not to offer a comprehensive explanation of the failures in governmental response to Hurricane Katrina. Such an analysis should properly incorporate many other factors, such as the decline in the capacity and influence of FEMA during the Bush administration, the impact of the creation of the DHS, and the complexities of inter-governmental collaboration (some of which are touched on in the conclusion of this note). Instead, the goal of the case is to understand just one relationship, albeit a critical one, in the broader Katrina response, and ultimately to understand the potential for collaboration in emergency conditions.

This teaching note summarizes the case, identifies a series of questions that can be used in teaching the case, and provides some additional detail to give the instructor a deeper understanding of some of the key analytical factors at play in the case.

This case was an honorable mention winner in our 2008 “Collaborative Public Management, Collaborative Governance, and Collaborative Problem Solving” teaching case and simulation competition. It was double-blind peer reviewed by a committee of academics and practitioners. It was written by Donald P. Moynihan of the University of Madison-Wisconsin and edited by Khris Dodson. This case is intended for classroom discussion and is not intended to suggest either effective or

Central Points of the Case

A number of facts are central to the case narrative.

- In the days immediately before and after landfall, the DOD response was sluggish. This created a delay in the application of federal resources to New Orleans.
- On the day after landfall, leaders in the DOD met and decided they needed to treat Katrina unlike normal disasters, and to respond much more aggressively.
- The move to a "push" response saw the rapid deployment of military resources, and was instrumental in improving the federal response.
- Even as the DOD became more aggressively involved in the response, it did so on its own terms. It established its own command, and frequently did not coordinate with FEMA and other agencies.

The case suggests some reasons for these outcomes, discussed in greater detail below:

- The nature of crises makes it difficult to rely on trust-based relationships in crisis response networks as a basis for coordination. Some of the actors are in the network because they are required to be, while others may have little capacity to actually connect with the formal response.
- The organizational culture of the agencies involved affects their view of and engagement in collaboration with others.
- Organizations can use established bureaucratic procedures as a barrier to interagency collaboration.
- Organizational leaders play a crucial role in setting the terms for collaboration.

Using the Case in a Classroom Setting

The case has been used in Masters of Public Affairs classes. The structure of the case does not follow the decision-forcing model of many case studies, since the correct decision (whether the DOD needed to engage

aggressively or not) is fairly obvious in retrospect. The case can be used to address a variety of analytical questions, outlined below. For these reasons, the specific questions the student should address are not laid out in the text of the case itself (though hinted at briefly, right before the conclusion). Instead, the expectation is that the instructor will identify one or more specific questions and assign them with the case.

In teaching the case I have asked students to write a two-page memo dealing with one of the aspects of collaboration discussed below (culture, red tape, leadership, and the logic of coordination amid crisis), and the case was then discussed for about an hour in class. It is helpful to have students cover readings on the key topics ahead of the discussion in order to place the case in a broader theoretical framework. The following section lays out a series of questions that would be a suitable set for students undertaking a case memo, or simply to introduce in class discussion. For each question, I point to specific readings that would provide the students with a theoretical framework to answer the question.

Questions for Class Discussion/Case Memos

1. What does the case tell us about the potential for collaboration in crisis situations?

The coordination of different actors in crisis response is inherently difficult. Collaboration is usually developed over time, based on incremental mutual adaptation and consensus between organizations. Members of networks learn to trust one another based on shared working relationships that provide evidence of reliability and mutual respect. But crisis responders often have limited prior contact with one another. They are expected to quickly come together, and coordinate to perform a series of difficult and unusual tasks they have little experience in.

The crisis management policies represented by the National Response Plan (now the National Response Framework) and the Incident Command System do not fully resolve these problems. By pre-designating federal responsibilities, these policies seek to make clearer the different roles involved in the process. This approach has three problems.

First, it relies on a “pull” approach to disasters, which assumes that FEMA and state responders will identify needs and communicate them to other agencies. This model works least well in a catastrophe such as Katrina, where time is limited, the needs are extraordinary, and the capacity of a central coordinator to communicate all of its needs in detail can quickly become overwhelmed. The early DOD stance during the Katrina disaster illustrated the weakness of this approach. By waiting for requests, and requiring that these requests be procedurally correct and detailed, the DOD slowed their ability to pre-position resources.

Second, the case illustrates how much the actual engagement of agencies in crisis response networks depends upon the willingness of these agencies to collaborate. The DOD was not the only federal responder that did not quickly rush to fulfill its responsibilities (the case also notes that the Department of Health and Human Services was slow in fulfilling its role in dealing with dead bodies, and that even the actions of DHS officials were marked by slow response). The fact that responsibilities are pre-designated and that an incident command exists does not mean that the incident commander has hierarchical control over the agencies involved. These agencies retain a high level of discretion in determining how, and to what extent, they engage in the response network.

Third, the National Response Plan largely neglected the emergent aspects of the network. As the case conclusion notes, any major disaster will see huge numbers of voluntary aid offered to responders. Most of these organizations have no prior contact with the incident command, or are familiar with the concept of the ICS. In the midst of the disaster it becomes difficult then to include them in the response effort.

Readings relevant to question:

Link to the National Response Framework: http://www.fema.gov/emergency/nrf/ McGuire, Michael. 2006. Collaborative public management: Assessing what we know and how we know it. ***Public Administration Review*** 66 (special issue): 33-43.

Milward, H. Brinton and Keith Provan. 2006. *A Manager's Guide to Choosing and Using Collaborative Frameworks*. IBM Center for the Business of Government. http://www.businessofgovernment.org/pdfs/ProvanReport.pdf

Moynihan, Donald P. 2008. Combining Structural Forms in the Search for Policy Tools: Incident Command Systems in U.S. Crisis Management. *Governance* 21 (2): 205-229.

2. What does the case tell us about the affect of organizational culture on collaboration?

The case notes one particular aspect of military culture, which is a desire for autonomy and a suspicion of non-military missions. The initial reluctance of the DOD to move from a reactive stance reflects a concern about the risks of working with other agencies and what the Senate report on Katrina described as "'a cultural reluctance' to commit Department assets to civil support missions unless absolutely necessary."

In Congressional testimony, DOD officials were largely diplomatic about other agencies, but one exception came from Assistant Secretary of Defense for Homeland Defense, Paul McHale, when asked about coordinating DOD resources with other agencies. He suggested that having a FEMA or DHS official in charge of DOD forces was "a bad idea," telling the Senate that "you can decide whether or not it would have been a good idea for Secretary [sic] Brown to have command authority over General Honoré's forces in New Orleans."

A desire for autonomy and a reluctance to engage in non-military operations are not the only aspects of military culture. The military also views itself, in the words of Samuel Huntington, as "the government s obedient handyman performing without question or hesitation the jobs assigned to it." In the military world, obedience is characterized not by simple rule adherence, but by the aggressive pursuit of organizational goals, a "can-do" attitude that sometimes clashes with formal constraints (Romzek and Ingraham 2000). This culture would become apparent in the second period of the DOD response. Then, the DOD no longer waited for FEMA requests, but instead started to deploy resources. To speed up deployment, the DOD used vocal command rather than detailed processing of requests. Honoré typified this spirit, consistently pursuing a strategy of acting first, rather than waiting for specific orders or requests for help.

An observant student should be able to figure out that a desire for autonomy would not explain the energy that the DOD provided in their response in the second period of the case. The "can-do" aspect of military culture is mentioned in passing in the case text, but is worth bringing into the discussion in greater detail.

It is too simplistic to say that one aspect of organizational culture came to dominate the other. While the later period of Hurricane Katrina was characterized by a "can-do" response on the part of the DOD, the underlying cultural attribute of autonomy remained, surfacing in new ways. While the DOD was certainly responsive in aiding FEMA, it defined the terms and timing of its help. In short, we need to understand both the autonomy and "can-do" aspects of DOD culture to fully understand their response in the case.

Readings relevant to question:

Khademian, Anne M. 2002. *Working with Culture: The Way the Job Gets Done in Public Programs.* Washington D.C.: Congressional Quarterly Press.

(Alternatively, Khademian, Anne M., 2000, "Is Silly Putty Manageable? Looking for Links Between Culture, Management

and Context," in *Advancing Public Management: New Developments in Theory, Methods and Practice,* J. Brudney, L. O' Toole, and H.G. Rainey, eds.)

Romzek, Barbara and Patricia Ingraham. 2000. Cross Pressures of Accountability: Initiative, Command, and Failure in the Ron Brown Plane Crash. *Public Administration Review.* 60 (3): 240-253.

Schein, Edgar H. 1992. *Organizational Culture and. Leadership*. Second Edition. San Francisco, CA: Jossey-Bass (esp. ch1-2).

3. How does leadership affect collaboration?

If there is a key moment in the case, it is the meeting of DOD leaders the morning after landfall, when they decide to re-orient DOD efforts from a "pull" to a "push" approach. By moving to vocal command, and making clear to responders that they should act where they saw an appropriate need, these leaders unleashed the full power of the US military. In doing so, they abandoned a course of action consistent with one aspect of the organizational culture (a desire for autonomy and suspicion of interagency collaboration), while drawing from another (the "can-do" spirit and willingness to work around rules to achieve a mission).

The case evidence does not suggest that agency leaders can create or easily modify organizational cultures (a point Khademian (2002) has made). Both of the major DOD cultural attributes discussed above predate any of the leaders involved. DOD leaders would not have been able to invent overnight any cultural attributes that did not already exist. Rather, the leaders recognized the need to switch between the two cultural modes, and were capable of making this switch.

One should not underestimate the importance or difficulty of culture switching. It requires an ability to recognize what cultural attributes exist within an organization, and when each cultural attribute is appropriate. In this case, it required an ability to understand when JDOMS procedures represented appropriate adherence to procedures, and when they were red tape. What the case evidence makes clear, and what DOD leadership recognized, is procedural rules that should be observed in some situations need to be abandoned in others.

The capacity of leaders to adjust their response required detailed organizational knowledge. It is of little use in offering broad demands for responsiveness – for example, Michael Brown frequently urged responders to "push the envelope" – without a detailed understanding of how organizational standard operating procedures will limit or further

responsiveness. In the case of the DOD, we see organizational leaders gradually changing their basic assumptions about the nature of Katrina and their role in it to recognize that a) this was not an ordinary crisis, b) prompt action by the DOD was necessary, and c) they could not rely on standard processes for incorporating the DOD response if they were to be effective.

The importance of such organizational knowledge becomes clearer when we consider some of the other actors in Katrina. DHS leaders failed to grasp the importance of Katrina in a timely fashion. Secretary Chertoff did not declare an Incident of National Significance until late the day after landfall (several hours after DOD leaders had decided to take a more aggressive approach). But even when DHS leaders acknowledged the seriousness of the situation they lacked detailed organizational knowledge of their resources and capacities. For example, there was confusion on the relative roles and responsibilities of the Principal Federal Officer and the Federal Coordinating Officer on the ground, limiting the ability to establish unity of command. In large part this lack of organizational knowledge was because the DHS itself was a new organization, and the crisis management policies that it introduced in 2004 were untested. In addition, the DHS suffered significant turnover of both career and political staff before Katrina. This limited the capacity for agency leaders to develop the type of experience and knowledge of both organizational culture and procedures that counterparts in the DOD enjoyed.

Readings relevant to question:

The concept of culture-switching is not one that has been explored elsewhere as far as I know. However, the Khademain work cited above gives useful arguments about the difficulty of using culture to manage. In addition, the work of Karl Weick on sensemaking by leaders is useful to explaining the differences between DHS and DOD leaders

Weick, Karl E. 2001. Making Sense of the Organization. Oxford, U.K.: Blackwell Ltd.

4. How do organizations use rules to limit collaboration? How does organizational culture mitigate the effect of red tape?

From the DOD point of view, JDOMS provides a buffering mechanism that ensured that it did not undertake unsuitable missions or engage in unnecessary interagency action. But the affect of JDOMS procedures was to make it more difficult for FEMA to know when, in what manner, and to what extent, the DOD will offer its help.

From the point of view of FEMA, JDOMS represents a form of red tape. But what constitutes red tape depends upon where you sit. The DOD perspective on whether the JDOMS constituted red tape changed only as the organizational goal- set changed and leaders decided to pursue a more aggressive response to Katrina. During period one of the case, the JDOMS procedures were not viewed as red tape by DOD officials, because they effectively served their purpose of maintaining organizational autonomy.

In period two, organizational leaders decided that responding to Katrina was a primary organizational goal, and that the usual rules had to be set aside. In this period, the "can-do" cultural aspect of the DOD mentioned above was also associated with a tendency to bypass organizational rules in order to get the job done. Romzek and Ingraham (2000) observe this cultural tendency in another military setting, the crash of the Air Force transport of Clinton Commerce Secretary Ron Brown. They note that the willingness to bend the rules to get the job done can be problematic if failure occurs and leaders must explain their actions consistent with rule-based standards of accountability. Pandey et al. (2007) also identify a broader tendency in non-military settings for public organizations with more entrepreneurial cultures to work around rules in order to further goal-achievement.

The contingent nature of administrative rules becomes significant when we consider the increasingly networked nature of not just crisis response, but almost all forms of governance. Competing definitions of what constitutes red tape among a network of actors will shape the perceived costs of coordination, a central factor in the calculus of cooperation that networks depend upon. Organizations can create and use procedural rules to limit or define the nature of collaboration. In this respect, procedural rules can become fences between organizations. Or organizations can revise, interpret or ignore rules in order to further collaboration.

Readings relevant to question:

Pandey, Sanjay K., David Coursey and Donald P. Moynihan. 2007. Overcoming Barriers to Organizational Effectiveness and Bureaucratic Red Tape: A Multi- Method Study. *Public Performance and Management Review* 30(3): 371-400.

Romzek, Barbara and Patricia Ingraham. 2000. Cross Pressures of Accountability: Initiative, Command, and Failure in the Ron Brown Plane Crash. *Public Administration Review.* 60 (3): 240-253.

5. What is the logic of coordination that drove collaboration?

Network research emphasizes the importance of trust and reciprocity, and to a lesser extent resource acquisition, as central logics of coordination. As discussed above it is difficult to develop trust in crisis response. Since actual crises are rare, emergency responders tend to build relationships in virtual experiences, such as pre-planning and simulations, but these are imperfect substitutes for actually working together.

While much of the research on networks focuses on organizations whose network involvement is voluntary, public service networks usually involve some network actors with mandated responsibilities, meaning that they cannot exit if they feel they are not benefiting from the network. For crisis response the National Response Framework mandates specific responsibilities to different federal agencies, and so these agencies have a political responsibility to commit resources to the response.

A political responsibility is a different impetus for collaboration than trust and reciprocity, or resource acquisition. The DOD helps FEMA because they are required to do so, rather than out of expectation that it will gain something in return. A logic of coordination based on political responsibility has distinct implications. It means that agency leaders are more concerned with the potential for political blame than with maintaining good relations with the other network member. This will usually compel the agency to try to work with others to avoid being seen as shirking responsibilities.

But if agency leaders perceive the response as failing they have a strong incentive to a) shift blame to other network members, and b) disengage from another network member if they believe they can be more effective through independent actions. We see elements of both these behaviors in the DOD response during Katrina. In Congressional hearings, some members of FEMA blamed the DOD for being too slow and bureaucratic in providing support during the initial stages of the disaster. The DOD, in turn, blamed FEMA for failing to provide detailed and timely requests for aid. As DOD leaders decided that they could not rely on FEMA to provide appropriate direction, they engaged largely through independent actions that showed an active and aggressive response, but not full collaboration.

A counterfactual worth discussing is whether it would have been possible for the DOD to pursue both an aggressive response that would also have been more collaborative. Or, was the implicit judgment of the DOD correct? (i.e. that there was a tradeoff between their effectiveness in responding to Katrina, and the level of collaboration they engaged in).

The case focuses on the FEMA-DOD relationship, but it is also worth noting that the lack of reciprocity mechanisms is not limited to

collaboration between federal agencies. It also applies to intergovernmental relationships. The federal level helps states and localities because it is a political responsibility, rather than out of the expectation of gaining something in return. States and localities welcome this aid when it provides resources, but are wary of loss of control over the response and the potential for being blamed for a failed response.

In the Katrina case Governor Blanco and her staff believed that the White House was seeking to blame the state of Louisiana for the failed response. When the White House tried to convince Governor Blanco to federalize the National Guard, Blanco declined for this reason. Her Chief of Staff said, "It was a proposal to allow the federal government to claim credit for the corner being turned on the ground in New Orleans." Blanco herself blamed FEMA for delays in the failure to provide buses for evacuation.

Weeks after Katrina, concerns about autonomy and blame-shifting affected the federal-state relationship during the response to Hurricane Wilma in Florida. Here, state officials who had watched the Katrina response refused to accept the authority of the DHS or agree to the appointment as a Principal Federal Official, and named their Governor (the president's brother, Jeb Bush) as incident commander to prevent a federal actor from trying to command the response.

By contrast, it is instructive to look at the two most striking examples of large- scale positive coordination during Katrina.

1) The massive support given by other states to Louisiana, Mississippi, and Alabama: Almost 50,000 National Guard and almost 20,000 civilians were activated through a pre-established agreement, called the Emergency Management Action Compact. States provide this support in the expectation that the receiving state will cover the costs of this support, and that similar help will be provided to the giving state if it faces its own emergency. The support is therefore governed by norms of reciprocity.

2) Coordination of National Guard and active-duty forces: tensions between the White House and Governor Blanco about the role of Louisiana National Guard were resolved largely because General Honoré and the head of the Louisiana National Guard, Adjutant General Major General Bennett C. Landreneau, had a long-term personal friendship that fostered an informal working agreement on the use of troops. In his Senate testimony Honoré notes, "the art of command is to take the situation as you find it, sir, and unconfuse people....And that's what General Landreneau and I did by standing outside the same tent outside the Superdome, was to work together in collaboration to achieve a unity of effort, not through staff, not by long distance, but the most personal way that can happen, face to face, and collaborated decisions."

The two examples of collaboration demonstrate the benefits of reciprocity and prior relationships, but these conditions were not common during the Katrina response, and the case mentions that post-9/11 policy changes actually undermined the potential for intergovernmental collaboration. Prior to Katrina, the capacity of FEMA was severely undermined, resulting in weakened relationships with state level officials. After 9/11, FEMA was made part of the new DHS, losing direct access to the White House and some key responsibilities. FEMA lost the responsibility of consolidating emergency response plans into a single coordinated plan. This role was crucial, since the resulting National Response Plan outlined new crisis management concepts and structures such as Incident of National Significance and the Principal Federal Officer. These were marked departures from previous policy and confused roles and responsibilities during the Katrina response.

FEMA lost a key function – preparedness. The basic design of a crisis management system – mitigation, preparedness, response and recovery – assumes a consistent, integrated approach across these functions. The loss of the preparedness function limited FEMA's ability to influence state preparation and weakened relationships with state responders. Preparedness grants became the responsibility of Office of Domestic Preparedness which used the grants to emphasize preparing for terrorist events rather than natural disasters.

FEMA also lost planning resources, another means to build relationships between state and federal responders. FEMA sought $100 million for catastrophic planning in FY04, and asked for $20 million for a catastrophic housing plan in 2005. Both requests were denied by the DHS. At a more specific level, FEMA struggled to fund the Hurricane Pam exercise (which predicted the actual Katrina event with startling accuracy) for five years. Even then, the exercise was not funded sufficiently to cover such issues as pre-landfall evacuation, and a follow-up workshop was delayed until shortly before Katrina because FEMA could not find $15,000 to pay travel expenses. One additional effect of the decline of FEMA was that senior managers left as morale declined, taking with them years of experience and long-term relationships with state responders, and further reducing the potential to use prior relationships as a means to foster collaboration once Katrina occurred.

Readings relevant to question:

Milward, H. Brinton and Keith Provan. 2006. *A Manager's Guide to Choosing and Using Collaborative Frameworks*. IBM Center for the Business of Government. http://www.businessofgovernment.org/pdfs/ProvanReport.pdf

O' Leary, Rosemary and Lisa B. Bingham. 2007. *A Manager's Guide to Resolving Conflicts in Collaborative Networks.* IBM Center for the Business of Government. http://www.businessofgovernment.org/pdfs/olearybinghamreport.pdf

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National Response Framework and Incident Command Systems

Link to the National Response Framework: http://www.fema.gov/emergency/nrf/ Moynihan, Donald P. 2008. Combining Structural Forms in the Search for Policy Tools: Incident Command Systems in U.S. Crisis Management. *Governance* 21 (2): 205-229.

Footnotes

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