UNIVERSITY OF HOUSTON

ORAL HISTORY OF HOUSTON PROJECT

HOUSTON'S RESPONSE TO THE VICTIMS OF HURRICANES KATRINA AND RITA

AN INTERVIEW WITH

Dr. Herminia Palacio

Dr. Herminia Palacio, Executive Director, Harris County Public Health & Environmental Services, Houston, Texas, was interviewed on August 8, 2006, in her offices at 2223 West Loop South, Houston, Texas. Her role in the Katrina rescue represented a broad spectrum of public health issues that arose in the Astrodome and the Reliant Center complex, which in turn required her to deal with municipal to federal government agencies. This interview gives insight from the perspective of a major responder and the effects that a disaster has on the community, the families, and the individuals on both sides of an evacuation event.

The interview was conducted by Ernesto Valdés, Center for Public History, University of Houston where the tape is deposited in M.D. Anderson Library on the main campus of the university.

TABLE OF CONTENTS

UNIVERSITY OF HOUSTON
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Interview with: Dr. Herminia Palacio
Interviewed by: Ernesto Valdes
Date: August 8, 2006
Transcribed by: Suzanne Mascola

EV: I am at the office of Dr. Herminia Palacio at 2223 West Loop South. It is August 8, 2006. I want to explain a couple of things to you first. These tapes that were are taking are going to go into the archives at the University of Houston, and we are primarily interested in trying to develop a history of the infrastructure of the various agencies – volunteer, nonprofit, and governmental that were involved in the Katrina relief. We will have this particular tape transcribed and I will send you a copy of it if you wish to edit and look at it. And then, I will edit my "ahs, ers" and stuff. And then, we will send the final copy. If you have any type of photographs or something that you might be able to contribute, a CD, a resume or something to kind of flesh out the thing . . . in effect, it is going to be your time capsule of your role Katrina relief. If I say anything or I ask a question and you want a time out or want to go off the record, just let me know and we will do the time out on it. And I guess that is it. Do you have any questions on anything?

HP: No, tell me a little bit about the project. You don't have to say this on the record if you do not want – just the project.

(Paused the tape)

EV: Would you give me your full name please?

HP: Herminia Palacio.

EV: And where were you born?

HP: New York. The Bronx.

EV: Why am I not surprised? Would you mind giving us the date?

HP: 1961, October of 1961.

EV: And tell me a little bit about your education, where you went to school.

HP: How far back do you want me to go? I am a New Yorker – I could start at PS 53.

EV: Did you stay in the Bronx the whole time for your education?

HP: I stayed in New York through medical school and I left after medical school. So, I did my high school in the Bronx. I went to Bronx Science. That was kind of a unique opportunity. I also did my undergraduate in New York at Barnard College. I did medical school at Mount Sinai School of Medicine. And then, I moved to San Francisco for a residency.

EV: Boy, that was a bad gig, wasn't it? (Laughter) So, after that, where did you go?

HP: Well, I was in San Francisco for about 15 years actually. I sort of grew up professionally in San Francisco. I grew up personally in New York and grew up professionally in San Francisco is sort of the way I think about it. I was in the Bay area, did my residency training in internal medicine. Then, after I was all done and had worked for about one year, I started to sort of follow a little bit of my heart and went back and got my masters in public health at Berkeley. So, I stayed in the Bay area. I was sort of floating back and forth between academic medicine and public health practice – being a little bit odd on either side of the fence thinking about the health issues a little bit more than my colleagues. I was in academic medicine frequently and sort of also interested

still in pursuing grants and writing papers when I was on the public health side. And was there until 2001, actually. We moved here one month . . . right after Allison, one month after Allison is when I moved here.

EV: You missed Allison?

HP: We missed Allison.

EV: "We," being your husband?

HP: Yes, my family moved here. I am actually the trailing spouse in the deal. We moved here because of my husband's job.

EV: Where does he work?

HP: M.D. Anderson.

EV: Is he a doctor? Is he also a physician?

HP: Yes.

EV: And you landed this job with the county?

HP: No, actually when I was here, there were not very many public health jobs available and so I went back into academic medicine and was 1-1/2 years at Baylor College of Medicine. I then moved my way back into public health practice on a full-time basis although I kept an affiliation with Baylor, but moved back here on a full-time basis in January of 2003.

EV: How did you wind up with this position that you have now?

HP: I mean, I applied for the position. This is the only position I have helped with the department.

EV: Oh, really?

HP: Yes. The executive director had resigned.

EV: Was it an existing office when you came or did you and the office come together?

HP: No, there was an existing office.

EV: Did you ever work in private practice, I mean, did you hang up your own little shingle?

HP: No. The closest I ever came to private practice was doing some urgent care, sort of jack-in-the-box type stuff at a number of clinics in the San Francisco Bay area. Private practice is not for me, or I am not for private practice is probably it.

EV: I take it you never had any military experience.

HP: No, I did not.

EV: So, effectively, you took over here, you said, in 2000 and what?

HP: January, 2003.

EV: I suspect you already had some experience in public health.

HP: Yes. I had worked in the San Francisco Department of Public Health for several years doing a fair amount of policy mostly. I was really doing a lot of public policy and health care policy, some policies, some research.

EV: What was your day-to-day routine prior to Katrina?

HP: Katrina? You know, a fair amount of administrative work but, you know, Harris County is very, very diverse and no two days look alike. That is one of the things that I really love about this job. It sort of forces me to learn something new every day, so there is always an opportunity to continue learning, which is very exciting. And always some new and unique challenges but a typical day would be, you know, either doing some administrative work, sometimes providing some medical direction for disease outbreak investigations – either food borne outbreaks or other epidemiological outbreaks.

Working with environmental public health section if there are spills or releases, you know, because of the petrochemical refinery. We are responsible for the mosquito control for West Nile virus or St. Louis encephalitis. So, we do a very broad gamut of activities – thinking about how we are going to increase immunizations, so it is pretty topically quite diverse.

EV: Now you have this bird flu you've got to worry about.

HP: I know, now we have bird flu, yes.

EV: Was Palacio your maiden name?

HP: Yes

EV: O.K. Is your husband also Hispanic?

HP: Yes, his father is from Mexico.

EV: Are they really?

HP: Yes.

EV: What part of Mexico is he from?

HP: Well, my husband is a Seattleite and my father-in-law is from Monterrey.

EV: When you go through your routine, when was the very first time you heard that you had to move in to the Katrina relief?

HP: I can tell you because of my phone bill – it was 5:08 in the morning of August 31. I got a call from Frank Gutierrez who was, at the time, the Emergency Management Coordinator for Harris County. And he called me on my cell phone and said that Harris County Judge Eckels had had a conversation with Governor (Rick) Perry and due to the evolving situation in Katrina, that we could anticipate . . . at the time, at that first phone call, it was somewhere between 17,000 and 23,000 folks, I think. They thought it was

going to be an evacuation basically from the Superdome to the Astrodome was the plan of evacuation with charter buses, and we were thinking that we had about a 36 hour lead time and he was just giving me a heads up and that there would be a conference call later that morning and a meeting later that morning and that is about all the detail I got.

EV: Did he short change you on the information?

HP: No, I think he shared everything that he had. The situation was evolving very, very quickly.

EV: So, I was just kind of curious what stats you were using. What position did you all have in terms of, if you were to draw an infrastructure, I guess the county judge and the mayor were kind of co-equals on this thing, right?

HP: Yes.

EV: What would you say, for example, of Dr. Mattox and the city . . .

HP: Yes, I was the Medical Branch Director, so I reported . . . you know, there was an Instant Command System and a Unified Area Command and I reported up technically through the Operations Section Chief but really reported fairly directly to Lieutenant Joe Leonard.

EV: Did you have daily meetings that you attended?

HP: Oh, yes. Absolutely. I was in the role as Medical Branch Director, which I discovered at 9 o'clock that morning when I walked in and there was a little box that said "Medical Branch-Palacio." That is how I knew about the assignment. Well, certainly that entire day of planning on August 31 was almost all planning meetings. And then, once we were operational, I was at Reliant usually no less than 18 hours at a time and we had formal meetings in the incident command structure, we had 3 meetings per day-shift.

EV: The folks were staying in the Astrodome . . . the Reliant Center is kind of across the parking lot from there, right?

HP: Well, we called it the Reliant Park Complex or Reliant City, is basically sort of the term that we coined. And so, as the situation evolved, the first folks that we received, we received into the Astrodome for a variety of reasons including some space limitations and the needs of the population and some fire safety code issues. We weren't able to accommodate all of the evacuees in that one building. So, then the next few thousand folks made it into Reliant Center. And then, that filled to capacity. And then the next few thousand folks make it into Reliant Arena, so we were operating the shelter – it was a mega-shelter – operated out of 3 buildings on the Reliant Park complex.

EV: And the Reliant Park is the old Astrodomain?

HP: Right. It has the Astrodome and then several other buildings.

EV: And then, the Brown Convention Center became the city's charge?

HP: It opened up a few days later to handle some additional overflow and in terms of the Unified Area of Commanders, Lt. Joe Leonard, was still overseeing both operations. There was a separate incident commander that reported up to Joe but was running over the George R. Brown. And then, there was a separate medical branch over at George R. Brown……

EV: I assume that there was collaboration going on between the two.

HP: Yes, absolutely. Dr. Persse was very active in the George R. Brown and we probably talked to each other 20 times a day…we were practically joined at the hip.

EV: Were you involved with the transportation of people that came over from New Orleans?

HP: Not in the transportation of folks who came over from New Orleans. In fact, none of us really that much control over that situation and there was not a lot of information forthcoming there. The New Orleans infrastructure, the communications infrastructure was essentially taken out. And so, we had no good intelligence over the number of folks that were coming, the number that were coming or how many buses were coming. In fact, at one point, there was such a dearth of information that Lieutenant Joe Leonard actually worked with the media outlets and had media helicopters flying over to look at I-10 and they were giving us information about how many buses were coming down the freeway and we would make some assumptions about how many folks . . . if there was a big caravan of buses, how many folks we might expect to arrive.

EV: Did you work by any chance with that VOAD – the Voluntary Organizations in Advance of Disasters?

HP: Not directly. We did have somebody who was . . . in the unified command structure, there was somebody who was designated to do the volunteer coordination so I worked with those folks.

EV: Now, you have about 30 some odd clinics that are under your immediate jurisdiction?

HP: No, my immediate jurisdiction, we have 5 preventive health clinics and we have about 13 additional WIC sites, more or less. And really, we don't provide primary care services. We provide things like what we consider clinical prevention services – immunizations, but outside of the context of the primary care setting – immunizations, family planning, and maternal child health.

EV: And the latter part of your title, environmental . . .

HP: Environmental services.

EV: What does that comprise?

HP: Well, in fact, we have recently undergone some reorganization so we have a division that is called Environmental Public Health and really, the large areas of responsibility for that division are air quality, food safety and water quality – both drinking water quality and waterways. Harris County, as you know, is the third largest county. There are two full-service health departments – ours, and the City of Houston. Harris County has over 1 million people in the unincorporated areas and it has another 29 or 30 municipalities outside of the City of Houston, and depending on the service, we are the only game in town for the 1.2 million unincorporated people in Harris County. We do some services by stack shoot for all the other 30 municipalities and some services by contract or memorandum of understanding. And then, for things like vector control for mosquitoes and also for refugee resettlement, we do the entire county including the City of Houston.

Because of the Ship Channel industrial complex, environmental public health does a lot of air quality monitoring. We try to make sure that there is no violation of folk's permits. We are trying to ensure compliance so that there is not release of noxious chemicals or spills. We inspect the restaurants out of that division. We also inspect the many, many public drinking water systems in Harris County, you know. There is not a single municipal or single county drinking water system. There are well over 600 just small drinking water systems and we are out there inspecting those as well.

EV: Did you utilize any of these neighboring counti in any way for the refugees?

HP: Many of the municipalities certainly made a contribution to the evacuees – both by housing evacuees in their communities unrelated to the operation but also very much so in terms of assistance with things like ambulance services or law enforcement services right at Reliant complex.

EV: My understanding is that one of your typical days once everything got set up was fairly busy.

HP: Yes.

EV: And that you were going from place to place to place to place. Is that a pretty accurate description?

HP: Yes. Things were very, very, very busy, and this was, I think now that I have had some time to reflect on that, it was a very sobering experience. First of all, it was a tremendous privilege and a tremendous responsibility sort of combined together. It was truly a privilege to be part of this effort and to be part of the big group that was there trying to do its best. It was also a tremendous amount of responsibility being asked to be the Medical Branch Director and frankly not knowing what Medical Branch was going to look like because nobody had done this before. And so, there was no nice little book off the shelf that we could pull and say, well, how do you plan for that? There was nobody that we could call to say how have you done this before?

I was fortunate to be able to have been here long enough to have had some good relationships and those relationships were tremendous in being able to identify what resources we might need and also being able to acquire those resources. And much of what we were able to pull off frankly happened sort of just as a result of informal conversations with people during the day. But we were responsible for everything. The

clinic got a lot of air-time as well as it should but Medical Branch was responsible for essentially setting up a public health department for a city that went from a population of 0 to 27,000 in 2 days. And so, really, we think about it as sort of setting up a public health infrastructure. So, that meant we had to be attentive to things like sanitation. There were public bathrooms that weren't meant to accommodate this size population in a short period of time, so there were sewerage problems. In fact, one of our private companies that came and donated time, CVS Pharmacy, had a sewerage overflow problem from one of their trucks that we needed to go deal with.

There were issues about monitoring indoor air quality as well as outdoor air. We had carbon monoxide that we needed to monitor because we had a lot of vehicular traffic including ambulances that were going in to enclosed spaces so we needed to make sure that they didn't unnecessarily risk the population to carbon monoxide poisoning.

We had blood borne pathogen issues that we needed to address, as folks really tried to establish some of the trappings of normal life and these barber shops got stood up. We had to think about issues of regulation of the barber shops to make sure that there was no opportunity to transmit infectious disease because now this was not a license and they didn't have the proper facilities to do some of the sanitation. We were doing food inspection to make sure that the food was being handled appropriately as we tried to feed 27,000 folks every day. We were doing epidemiologic investigations, you know. We had an outbreak of gastrointestinal illness and wanted to use our good standards of public health practice to try to get that under control. So, we were doing everything that I do every day here, we had to do there, but I also had to make sure that everything that we do

every day for our general population was still getting down. I mean, we couldn't just shut down.

EV: So, when you said you had a lot of things to reconstruct, what did you do? How did you conceive these ideas and designs of your services and dispense them?

HP: Well, for the clinic, I had a conversation with David Lopez, the president and CEO of Hospital District and it was about 3 p.m. that day, we happened to be together in a meeting. I went and sat next to him. I had some idea of what we thought we needed. We way underestimated what we would need for the clinic but we had some estimates. I said, "David, I need your help." And he said, "What do you need?" And I gave him some of my estimates. He walked out, he got on his cell phone, he came back in, he said, "Talk to Chris Ochizi (sp?). He is expecting your call." And we talked to him. By 2 o'clock in the morning, the Hospital District was setting up some of the infrastructure for the clinic for me. They had worked through the contractor and they were setting up some of the sources. They were also getting some of the staffing requirements lined up.

In terms of many of the other aspects, we also started out with a skeletal staff but added staff so that from a public health practice standpoint, for every 24 hour period, I had over 80 staff members physically present at Reliant, doing food inspections, doing air quality carbon monoxide poisoning, working with the folks who set up barber shops, you know, working with a number of ad hoc issues that kind of arose such as child care and other issues. Doing very sophisticated epidemiological analyses.

EV: Where did these guys come from? I mean, did the call go out for we need people with experience in how to monitor this stuff?

HP: They came from my staff.

EV: So, the extra people you got on were part of your staff already?

HP: The 80 folks that I had a day were part of my staff, so they were working overtime and everybody back here was working overtime because they had to pick up the slack of the 80 folks that I had over there. So, this was a huge departmental commitment and effort. And then, in addition to that, we received about 20 folks from CDC (Center for Disease Control) for about 1 week during that. Some were around day 5 and they came . . . for about 1 week, we had a full 20 or so and then that dwindled down. So, that helped us well tremendously.

EV: So, what were the different spots in which you felt compelled to see every day, to keep almost a constant command or in constant touch with?

HP: Well, you know, I was in the command center a lot. I tried to get out and visit the shelter areas every shift because there was some assessment that I needed to do just by eyeballing it. I didn't visit the clinic every day. The clinic was really quite operational and Dr. Tom Gavagan was sort of really took charge of leading that operation. So, Dr. Gavagan and I would talk every day multiple times a day but I didn't get out to the clinic every single day. Just walking the grounds. You know, it was really kind of walking the grounds. I mean, some of the carbon monoxide monitoring, for example, I would do myself, you know, if it was midnight and we needed to run out because there was a diesel bus arrived.

EV: Would someone on your staff just say . . . it seems to me there would be an oversight on something this massive to say, man, all these ambulances coming up here, all that exhaust . . . maybe I am not familiar with public health and there is probably

something that is on the forefront of your mind . . . it would never occur to me to worry about that but I guess a public health person, it is just second nature.

HP: Yes, you know, that was one of the things that walking the grounds, I was there. I was there within the first . . . I was there as the first buses were getting there. And so, I saw the ambulances and some of the shuttles coming in and yes, I guess it probably is second nature. I made the appropriate calls and the Houston Fire Department was very good and brought some of their monitors and my folks subsequently brought some of their monitors. So, like I said, it is sort of what we do every day, the skills and tools that we apply to that environment. But we had to do it on the fly.

EV: Just a bigger movie.

HP: And a much faster pace.

EV: Did you ever come home at night and say . . . did you ever come home at night?

HP: Did I come home? Let's see. I did come home. I probably never worked less than a 16, 17-hour shift. I probably didn't work that many 30-hour shifts. I probably worked a couple of 30-hour shifts and probably averaged around 18 hours. So, I wasn't home for long. I would leave and I would come home and I would crash for a few hours and then get back up.

EV: How long did this last, your part of . . .

HP: Physically at Reliant for 3 weeks. And then, I had a day back in my office. And then, I moved to Transstar for our department to roll in for Hurricane Rita preparation. So then, spent 3 nights at Transstar.

EV: How many folks did you take care of from Rita?

HP: From Rita, we had a different . . . because we were in the path, it was a very different set of operations. I had a skeletal staff at Transstar. I think there were 7 of us total, and really what we were doing is trying to make sure that we had good advance preparations, that we knew who was evacuated and that we were prepared. And one of the things, for instance, that we wanted to be prepared with to make sure that we monitored . . . you asked about the environmental . . . but to monitor the environmental situation, to make sure that if we were impacted, we didn't have any dangerous chemicals being released as a result of the hurricane or that we made sure that infected communities wouldn't be let back in if there was anything that released. And thankfully, none of that came to pass. We wanted to be monitoring water systems to make sure that if they were impacted, that we didn't need to send any boil water notices. So, it was that kind of preparation, understanding the kind of infrastructure damage that could happen in a hurricane so that we would be ready to act.

EV: Did you or any part of your staff actually meet the buses when they came in? I understand there was some kind of a routine that the doctors would get on the buses . . .

HP: Yes. It wasn't me personally but it was folks in Medical Branch. We had a lot of our volunteer physicians, a lot of the Baylor folks and other volunteer physicians would do the triage the first couple of days and then actually, we received an outside resource. We had requested a federal resource called DMAT, Disaster Medical Assistance Team. And several days into it, we received a DMAT which is the complement of about . . . I don't remember the exact number, again, sort of in the 20s in terms of the number of folks – a variety of skill sets; mostly nurses and EMT types, and they worked directly under the leadership of . . . actually Lieutenant Gary Scheibe (sp) of HPD kind of took

that part over and set up a pretty elaborate staging area where people would get triage very quickly coming off the bus. Houston Fire Department was also very active in some of the triage depending on what our staffing levels were.

EV: Were there any illnesses, diseases, afflictions that you weren't anticipating that came or that you encountered?

HP: Well, you know, our first guess, before anybody arrived, just watching the news coverage of what was happening in New Orleans, our first guess was that we were going to have a lot of folks with chronic disease who hadn't gotten their medicine. So, we were thinking about people who had diabetes, who would be in an unstable condition or who would have high sugars, and people with heart disease who might have chest pain. And that panned out to be pretty accurate. I would say one of the things that we probably hadn't given quite as much thought to that I hadn't personally was dialysis – the number of folks who would need emergent dialysis in that first couple of days. So, we did do a lot of emergency transport essentially right off the bus to the hospital for folks who had not had access to their dialysis treatment.

Other than that, I think the surprises were more in what we didn't see. We saw fewer injuries than I had expected to see. Overall, we really did not see much in the way of infectious disease outbreaks. So, I feel pretty good about some of the public health measures and we had some luck coming our way, too.

EV: How did you all deal with . . . I am going to ask you in two parts. How did you deal with the emotional impact that this had on the evacuees themselves?

HP: From a public health perspective, it certainly changed, to use some jargon, some of the control measures and how we implemented them, and I will give you an example.

When we started to see this gastrointestinal illness, we started to see folks coming in to the clinic with a lot of vomiting and diarrhea, and we were worried because we have got folks in very, very close proximity. Obviously, this is a ripe opportunity for a huge outbreak. So, this got our attention and caused some concern. And we were able to work to very quickly establish an area in one of the facilities that could serve as an isolation area so that people could recuperate while they were having their vomiting and diarrhea without infecting others. However, because of the emotional impact of the hurricane and because part of that emotional impact is really that we saw so many folks who had lost family members. I don't mean loss that family members had necessarily died but folks who really didn't know where their families were, had gotten separated from family members, we thought it was really important not to add to that trauma and stress. So, whereas the purest public health practice approach would have been to say, "O.K., you are going to be in isolation," we tweaked that in this situation and said, "O.K., we want you to be in isolation but I am not going to put you in this building with your family across the street in that building." Your family, if you choose, can go with you. I know your family is not sick and I know that I am increasing some risk for your family to get this gastrointestinal illness as well but I am trying to balance," sort of getting control of an infectious disease outbreak with trying to not further traumatize by our actions things that we did for the evacuees.

EV: What about the emotional trauma of the servers, such as yourself and the other workers?

HP: A good question. We'd talk about it a little bit and Dr. Maddox was very good at doing sometimes at the end of the day, a little Mattox Minute where he would give some

little anecdote. So, it was basically was caution that we needed to tend to ourselves. And while I think we all understood that intellectually, nobody really had time to address those issues and I think that the Unified Command did an outstanding job of really trying to preserve morale. And, as I said, part of it was just the privilege. So, I think everybody sort of . . . you know, we muddled our way through. I don't know that there was some magic bullet …or we muddled out way through.

EV: Well, you know, the rest of the community, if you were all not aware of it . . . you were so busy doing your work, I suspect there was a lot going on around over you or under you that you weren't aware of . . . what do they call it, "volunteer fatigue"? and some of the folks said that they did get . . . they just kind of wore themselves down with just the whole emotional trauma.

HP: Yes.

EV: I suspect if you are one of the . . . correct me if psychologically, this may not be a factor . . . if you are one of the evacuees, for example, or one of the folks who are hurting, and you are surrounded by other people who are hurting, you kind of have an even keel but if you are coming fresh out of where you just had a nice meal and nice clean clothes and you go into that every day, you carry a different mindset. Maybe it is pricking your conscience somewhat or . . .

HP: Yes, I don't know. It is hard to imagine. I mean, in terms of volunteer fatigue, we were astounded. I mean, whenever we put out a call for volunteers, we got volunteers that caused traffic jams we got such a response. We had over 60,000 folks volunteer. Over 60,000 folks. And they did everything. Everything from pick up trash to counsel people to you know just hold hands. I mean, it was pretty amazing. We were not . . . for

me, and I know that for several others but I'll let them speak for themselves. Walking through and connecting with the evacuees was, in fact, one of the tools to use to preserve mental health because it reminded us of why we were there and why what we were doing was so important. And it reminded you just how resilient the human spirit really is. You know, folks who had lost everything…everything in the blink of an eye . . . didn't not just know when they were going to get back, didn't know if they were going to get back. You know, to see folks, yes, be sort of shell-shocked for the beginning but, you know, regroup and sort of take the little tiny steps, do little things to try to make that situation seem a little bit more normal – you know, kids playing, establishing little family groups. There would be like instead of separate cots, people would start to put their cot together and build little, itty, bitty privacy walls with cots turned on their flip side just to sort of say this is our little family space – these 3 feet by 3 feet, the closest thing to a little home. People who reached out to each other. People who helped us, you know, who really helped us with outbreak control and things like that. Some of the evacuees became volunteers. It was a pretty inspiring kind of experience.

EV: Somebody had mentioned to me that one of the astounding things, and I don't remember what hour he said he walked in the Dome for the first time, but he was amazed at the silence of the place with that many people there. I expected to hear the din of humanity but he said he walked in there – it had to be the first morning when these folks first got there – they were just beaten down so badly and no one really said anything.

HP: Yes, I don't know that I remember being struck by the silence per se. I do remember . . . you know, it is hard. People are so different. And there were some people who were so resilient and there were some people who just looked vacant, who were

beaten down and who looked like they couldn't quite gather themselves together to figure it out, to figure out what to do next.

EV: Did your department have anything to do with transporting folks from meeting the folks who came in at Ellington Air Force Base?

HP: Well, Medical Branch worked with the unified command to sort of have some of that done. So, certainly some of the folks who were at Reliant, but it wasn't so much folks from my department. It was actually Mike Montgomery who is now the Emergency Management Coordinator for Harris County, played a very key role in some of the area transport stuff. So, we were in the loop and actually one of the Houston Fire Department folks, Captain Royal, was also very influential.

EV: Captain Royal with the Houston Fire Department? Is that what you said?

HP: Yes. Well, there are two Royals – one HFP, one Harris County Fire Marshall. They are brothers. They were both very, very . . . the Harris County Fire Marshall, Captain Royal, was the Deputy Unified Commander. So they were very prominent. Actually, he used to work for us. So that was kind of cool. It was nice to see people . . .

EV: Could you explain to us what the . . . the Unified Command, who comprised that?

HP: Sure. Lieutenant Joe Leonard who is Coast Guard and actually, I think, just got a promotion so he is beyond Lieutenant. He is Coast Guard and he was Unified Area Commander. And he was the Big Kahuna for the entire operations, both Reliant and George R. Brown. And then, he had two deputy commanders, Bob Royal from the Harris County Fire Marshall's office and Rick Flanagan from Houston Fire Department. And then, Mike Montgomery, who is both Harris County Fire Marshall and now the Emergency Management Coordinator that serves as the liaison officer so also in the

unified command structure. And then, beneath that, in the operations section, there were several branches and, you know, I was Medical Branch Director and then there was Law Enforcement with Captain Anderson was another branch and those are two of the huge branches that have big pieces…Law Enforcement had a huge piece. (extended pause) Lieutenant Leonard who had taught us . . . incident command system before that, he was one of our trainers, so they actually set it up to be a National Incident Management System compliant system.

EV: Did you already know him from before then?

HP: I did know him from before. We had had him come over to the department and provide training to our staff on incident command. So, I knew almost all of them. There weren't many folks in that command center that I hadn't met before.

EV: Do you know why, I mean, just out of curiosity, but also philosophical, why they would pick a military man…(laughing) while you mull that over….

HP: ….it is above my pay grade so you would have to ask somebody else. You know, he is Coast Guard but he is stationed here in Galveston. He is very well-known to the community. He works a lot with many of the folks there; can serve as both the principal federal official but just has a tremendous amount of experience doing disaster management type responses. I was happy to have somebody with that kind of expertise running the show.

End of Tape 1

Start of Tape 2

EV: At any time, did you have any moments of concern or anguish because things were not going the way you wanted?

HP: (Emphatic) You bet! (Laughter)

EV: Would you share those with the tape?

HP: I've got to be honest – there were many, many of those moments. There were probably several of those moments every day in part because the facts as we thought them to be were frequently not what they were, not what we were anticipating and so, while we were trying to lay out plans in advance to try to meet the challenges that we could anticipate, we also had to be very, very flexible. We had anticipated initially that all of the evacuees could be accommodated in the one building in the Astrodome. It became apparent really at 3 in the morning that that wasn't going to be the case. The next plan was to sort of redirect some of those evacuees to other locations. But then, we had a large number of buses pull in. I mean, I'll share with you sort of an anecdote to understand sort of how quickly things evolved.

I put together a slide presentation. Somebody asked me to go give a talk, and I put together the time line I was looking at. I said, "Oh, no, that can't be right. That is too fast. I had to have made a mistake in the time line." I went back and I pulled my notes and this was many months after the fact. And I thought, "Oh my gosh, this was right." Things moved that quickly. So, one night, we had 8,000 evacuees and by the next morning, we had 17,000. That is how fast people were coming in. And what we had considered to be, what might have seemed outwardly to be a rational plan which is redirect the buses to another shelter, you know, in those first 12 hours, we didn't really completely understand what kinds of conditions people were coming in, and the bus drivers basically said, "We are not moving another inch." They shut off their engines and they opened the doors and people poured out in front of the complex. Well, you have to

change your game plan. You can't just say, "No, we have closed down," and that is when the next building came on line. There were some calls made and we were able to get the next building we had on line but that was just one of a number of little mini-crises when you are trying to problem solve, when you are all sleep deprived and it is 3 in the morning, and you've got 600 people at the gate that you didn't know were going to be there.

EV: You said you opened up the other place. Were there cots in this place?

HP: No.

EV: Was there anything in there? Were they just kind of milling around waiting for something to happen?

HP: No. What we did was while we got the cots set up, we were doing things like getting folks water and bathroom access but all of this has to happen tremendously quickly and, you know, command staff leaving the command centers some of them and setting up cots. You did what you needed to do. There were times when . . . when we started to have this gastrointestinal . . . when we started to see an uptake of gastrointestinal illness, you know, that was another moment where I just thought oh boy, you know, we are going to try to get this under control. . . we don't know what it is yet. It turned out not to be something that causes serious illness so we were very happy about that. We were in circumstances where it was going to be very difficult to control. Can we really pull this off? Can we gain some control over this animal or is this going to unravel and really make people sick? So, yes, there was a lot of anxiety. There was a lot of anxiety, I would say, that I personally experienced as things seemed to either not go as planned or new information or facing challenges that you just didn't expect.

We had one situation where there was a childcare provider that we needed to work with very seriously to not be let on the premises anymore because things were not being done in a responsible way. We had mental illness crises that started out small but ended up taking 3 hours to resolve when there were other things that were backing up. None of this was easy, and there is lots of stuff that went wrong that we needed to correct or things that could have gone very, very wrong.

EV: Were these, without trying to get you to violate any trust or anything, can you give us an idea of what those mental illnesses might have been that you felt were crises?

HP: You know, nothing that, from a standpoint of a population is that surprising. You know, if you have 27,000 people, remember, that is bigger than many of the municipalities we have -- it is bigger than Bellaire, it is bigger than West U, it is bigger than a lot of our cities -- you are going to have some mental illness. But now, you've got some mental illness where you haven't been set up for the resources. So, it is really just a matter of, you know, do you have somebody that you think might be acutely depressive? What kinds of crisis intervention can you get for them? It is really a matter of sort of identifying resources.

EV: I mean, you didn't have anybody just flipping out? You are going to have the main ones, as you said, when you get into that percentage . . . Did you keep like a diary or notes of what was going on?

HP: Not so much a diary or notes because I didn't have time. Yes, I do have a little journal actually given to me . . . here is a real funny story of colleague taking care of colleagues . . . given to me by Dr. Mattox because he got tired of watching me flip through a bunch of papers and he went out and he bought me a notebook. (Laughter)

And I used that notebook sort of to keep track of tasks for myself, some of the skills that I reached back to, were skills that I learned as an intern which are, you know, write down your task with a little box next to it and you know, it doesn't get crossed off until it gets crossed off. So every day, I would have my little scut list of things that I needed to accomplish.

EV: Nagging at you until it got a little check mark.

HP: Right, because when you are in a situation that is that intense, you can't rely on just your memory or your sense of working, you really kind of need to do your due diligence and a lot of the good management is not so much rocket science, it is just paying attention to the detail.

EV: I assume you kept that notebook.

HP: I did.

EV: Would you let us Xerox copies to put in your file?

HP: I need to think about that. Finding lost family members and things like that.

EV: I had heard early in the collection of these oral histories that there was an instance of when they finally came out the door, they found a bunch of babies that had just been abandoned.

HP: Babies?

EV: Yes, young kids were just abandoned there.

HP: No.

EV: The person that told me this was so adamant that that is what happened. I mean, I was kind of stunned. But then, no one in the medical thing ever heard it so I assumed that didn't happen.

HP: No, I mean, that is one of the things that Medical Branch did – we worked very closely with Child Protective Services because we did have some unaccompanied minors who had gotten separated from their families coming down and so this was a constant thing of trying to reunite minors with their family members, but no, no... I personally was there when we shut down operations, walking the premises actually. There were no abandoned babies.

EV: What do you think you would suggest or what would you do differently if you had . . . I am sure you all had some kind of powwow and said, do we have to redesign . . . what were some of the things that might be done . . . we kind of know what was done that was going to be kept because a lot of people have spoken to that but how would you modify it or what differences would you make?

HP: Well, you know, again, probably not rocket science. I think you will hear from any disaster, sort of communication. One of the things that I think I would do differently from a medical branch perspective is to make sure that messages, that things that we communicate to our partners or to other folks who are working within that arena, that they are communicated frequently and in writing. And I think we didn't do as good a job doing that. And so, sometimes the first shift and the second shift, if there was a change in policy; let's say, isolation policy is actually one example of where this really happened. The first shift and the second shift got the isolation policy the way we intended it to be. But by the third shift, it is like playing telephone when you were a kid - by the third shift, the information had gotten changed and the procedure was being implemented in a way that I didn't know it was being implemented and it took me a couple of shifts to find out that it had been changed. So, that was a lesson for me - to be better about making sure

that I am clear about how to communicate a policy and that I have it in writing so that the next shift can actually come and look at it if there is evolution.

I think there are aspects of which we frankly got lucky and I am trying to figure out what we would do differently in a situation where we might not have been so lucky. For instance, the weather really, really blessed us in terms of, I think . . . this is all speculation but I think it terms of infectious disease control, it was wonderful that there were sunny skies almost every day and that the people wanted to be outside and not confined 24 hours a day in that Astrodome. So, that we had the benefit of folks separating themselves out. I think that we could have risked much greater infectious disease breaks had people really needed to be confined. So, we need to think about what are ways that we can allow people to further separate themselves out, some space where you don't have people on cot next to cot next to cot. And I don't have a solution to that yet. We just got lucky.

Certainly, in terms of staffing, as Medical Branch Director, I think I figured out that I needed to be able to communicate back to my headquarters more effectively than I was because it was so busy over there, I'd be trying to call back here to communicate about how we coordinate, you know, staffing and things like that and I'd say, "I'll call you right back," or I'd begin dialing and another call would come in. And so, there were some real challenges about trying to do too much and sort of learning how to delegate a little bit better.

EV: How much of that . . . when you say you had a problem with communication, how much does that plays into your observation of your need to communicate better as opposed to the physical phones or technology . . .

HP: This wasn't tactical because we weren't impacted. New Orleans, they lost infrastructure. We didn't lose infrastructure. You know, I had a cell phone, I had a radio, I had means of communication. I just didn't have time to have a conversation and did not . . . it took a few days to designate something that I think we will designate in all future disaster responses which is I had a staff member after a few days that was designated sort of as my liaison. It sounds very simple but it was somebody who just kind of, for important things, I could say, you know, come with me to this and then I could delegate; you know, call back and let so and so know such and such, rather than having to do all of that myself because when I had a long list of call so and so to tell such and such, it would sometimes be hours before so and so got called about such and such. And so, that, I think I could have made operations better.

EV: So then, one of the major problems then is finding time for the leaders like yourself who are in charge of stuff to have some clarity and some time found and some down time.

HP: Yes. This is another sort of anecdote. This is part of oral history, which you won't see in any newspaper. At shift change, my college, Dr. Shah who is my deputy director and we would do shift change. Well, we finally started escaping to the stairwell to do a good sign-out on shift change, because that was the only place we could find where we weren't going to get interrupted by a lot of requests. And we didn't tell anybody where to find us, you know. We found some isolated stairwell and that was where we did shift change. And then when we moved buildings, we would do shift change in a golf cart in the middle of a parking lot.

EV: You had a little mojita…(Laughter)

HP: So really kind of finding that time to communicate effectively so that we didn't miss things, we didn't miss the opportunity to communicate important information to each other. That was so important that we, like I said, did it in a stairwell because we recognized that that was important.

EV: Dr. Mattox, when I interviewed him, he seemed to be very gung-ho on delegation of authority. He told me he knew ahead of time a lot of things were happening. He had resources to know this kind of stuff. But he indicated that that was very important. The other gentleman, Dr. Jamison Day, who designed the program that they had at the Inter-Faith Ministries and their Neighbors-2-Neighbors program, he is a young Ph.D. out of U of H, said he designed that from his disaster experiences in Indiana in terms of what happens in a disaster – what are the first things you have got to set up. And it was interesting . . . ideas or things that just no matter what kind of disaster you have, there are certain things you need to do immediately.

HP: Right. Shift change was one of the . . . those little things that you don't think about necessarily in advance. You know, I come from a clinical training as a physician and I am very used to the concept of signing out. And so, with my colleague, Dr. Shah, you know, I didn't have to sign out to Dr. Mattox. Dr. Mattox sort of floated in and out in his sort of Deputy Medical Branch role. But we are good at doing shift change. I mean, nurses have that as part of their training. But a lot of my other staff, the public health practice, has not historically been a 24/7 operation. And so, I figured out that as an organization, we weren't as good at shift change as we needed to be because we didn't understand just how much information needed to be communicated and how to do that concisely because that is a practice, you know. You get better at that with practice.

EV: And for the purposes of our future readers here, the shift change, you mean passing the baton from one shift to another?

HP: Right. If I am doing the first 12 hours and you are coming in to do the next 12 hours, what do I need to tell you about what happened during my 12 hour period and what I hope happens during your 12 hour period? What do I need to tell you so that that happens smoothly? So that, if we've got something that is cooking, it doesn't get lost. So that, if we are looking for a family member because we've identified that her child has a medical problem and she is in Dallas because they went on different buses and I haven't been able to locate her yet, how do I make sure that you continue to follow that ball and locate her?

EV: What did you do in the situations where you had, or did you have situations where you had a sick or injured child and you didn't have the parents around? Did you just do what had to be done?

HP: It depends. Sort of, the usual standards of care. If it is life-threatening or immediately threatening, then yes, then there are opportunities to intervene but otherwise, we really spent time with either a surrogate . . . sometimes people would be there with somebody who could consent that was a family member or we would have to sometimes work with other agencies like Protective Services to get the appropriate consents.

EV: Do you know how they went about doing that? You expose yourself to some degree.

HP: Well, we worked pretty hard to do the right thing and to try to reach folks. We certainly weren't going to be in a position of letting any serious harm come to a child

because we couldn't contact an adult. Most of these situations were not so life-threatening but you didn't have time to contact them.

EV: But you can imagine a situation where you would have children who might have been injured and I am just wondering is there some procedure to call Child Protective Services and say, clear the way for us?

HP: No. I mean, in this situation, it wasn't life threatening. You know, clinicians will do what they need to do to save life or limb in the absence of consent. These were not situations . . . where we were working with CPS, dealing with situations, none of them was a save life or limb kind of thing.

EV: How close did you work with any FEMA personnel?

HP: FEMA was on-site at the Command Center, so we got to know all of the variety of FEMA representatives that were.

EV: The good, the bad, and the ugly? (Laughter)

HP: Indeed. Yes, so we got to work with the folks who were sent here as FEMA representatives. One of the problems was that they didn't have the full authority, I think, to speak on behalf of the agency. So, that was one of the . . . you talk about when you felt like things were going bad or things were frustrating, that was certainly one of the frustrations that we thought there were many instances in which we thought we had a good plan and FEMA headquarters would change that plan. Their agency's behavior would do something and not inform their FEMA rep here so we didn't know FEMA was about to do something.

EV: How much of your operation was under FEMA? They didn't have any authority to go into medical treatment or any of that.

HP: No.

EV: So, they were primarily for providing money and funds for readjustment or that type thing?

HP: Yes.

EV: So, in terms of FEMA, they didn't interfere with . . .

HP: With Medical Branch Operations? No, although clearly, we had a vested interest in having people be able to transition into more stable housing. Just from a health perspective, that was a better outcome. And so, things that put a road block into transitioning people out of the shelter and into a more stable situation certainly had an adverse effect on our ability to, number one, like I said, do good infection control because the fewer people we had, the easier it was going to be to do infection control but also there were some folks who really had some needs that were not . . . where a shelter situation wasn't the best place for them medically, and it would have . . . you know, trying to move those folks into a more appropriate level of care would have been better.

EV: Were you aware of the groups . . . there was a Hispanic barrio, several in New Orleans. I didn't know that . . . some of them were out of Town & Country. They apparently brought them from out there to the Dome or to Reliant and then they were transported back. You never heard of any of them? It is just as well. You don't need anything more on your list.

HP: Do you mean to the clinic that they transport _____.

EV: I forget who . . . they told me that they had called somebody and they had provided a bunch of taxis. There was a Hispanic Chamber of Commerce that provided gratuitous taxis to run these people back and forth from a Days Inn, I think, they had out

at Town & Country to the Dome for medical treatment, picked them up and took them back. I thought that was kind of an interesting thing and I just didn't know whether or not you had heard of them.

HP: No, we knew that we had folks . . . the Dome clinic was really set up to meet the needs because that population was so huge, to meet the needs primarily of our Reliant city residents and, you know, there were big operations to try to sort of manage some of that inflow but we recognized that there were some folks who were not there and these were very difficult choices because by no stretch did Reliant have all of the evacuees. We had a good 27,000 but there were an estimated 150,000 to 200,000 in the community, and George R. Brown only 4,000, I mean, so there were a large number of evacuees in our community that our clinic wasn't equipped to care for.

EV: Is there anything that I haven't asked you that you think might be included or we should know about?

HP: It is hard to capture or think . . . I think, in some ways, probably the one thing is the end of the story; you know, that folks that have come in from this horrible experience with Hurricane Katrina and that late September, the command staff had to go back in to those remaining in the shelter and say, "We can't take care of you here anymore because we are now looking at Rita." And the preparation, you know, as we recognized that that was what we were going to have to say, that was another one of those moments that just really makes you stop and takes your breath away for a little bit, because if you think about folks who are traumatized and we are trying not to traumatize them further, this was quite challenging. So, it is an unusual beginning and an unusual end.

EV: I was under the impression that the Rita people just kind of integrated themselves into the community.

HP: No, we closed Reliant. The shelter operations closed on Tuesday. I was in here in the office on a Wednesday and at Transtar on Thursday. The Reliant operations . . . we had to evacuate our evacuees. Talk about things that have never been done before. We had to evacuate our evacuees.

EV: Wow, where did they go primarily?

HP: Well, some chose to stay with friends and relatives in the outskirts of Texas or chose to find locations on their own other than what was being offered through the shelter operations. Those who took advantage of the shelter evacuation were evacuated to Arkansas out of the paths of danger. So, you know, they got from Louisiana to Texas and now were being told they have to go to Arkansas.

EV: Did the influx of Rita evacuees match . . . I know it didn't match the Louisiana but did it still challenge the system?

HP: Well, it was a different challenge because although we were fortunate that we dodged the direct bullet, we were close enough . . . now these were really our direct neighbors and we didn't get, at least I didn't perceive getting so much huge number of evacuees who stayed but really, we had to do a lot of outreach. At least, as an agency, we provided a lot of mutual aid to some of our little neighboring counties that took a big hit. So, we sent some of our staff to help them as they were trying to regroup, you know, our veterinary public health and a lot of animal control officers because stray animals and dogs in packs were actually a problem in some of the counties that had been hit.

EV: Abandoned animals? Do you mean people just leaving their pets behind and they formed their own packs or they already had existing packs out there?

HP: No, they weren't existing packs. It was from the evacuation from the distraught people who had to leave and had to leave their pets behind and couldn't get back, with strays and animals whose owners couldn't get back to them.

EV: What about the massive mosquito problem? That had to be . . . they obviously didn't have the resources to handle that there, did they?

HP: We were not asked for assistance for mosquito problems and I am not quite sure how Louisiana handled that. We did meet with the Louisiana health director, the National Association of City and County Health Officials that have arranged a meeting with their director and with me and with Mr. Williams from the City of Houston and actually, Mary Levine Kendrick, the former director of the City of Houston just to try to help them think about public houses they were looking to rebuild. I mean, they have to rebuild everything and it is just so different. One of the messages I guess I'd like to leave is people look to New Orleans and say, well, that didn't happen here. Well, it is not the same thing when you are in the path. You know, we were able to do what we did because I may not have gotten home much but I had a home to go to. You know, my family was intact. I wasn't worried whether they had drowned. We had electricity. We had food. We had water. We had lights. So, I could work hard. But I was just working hard. My life hadn't been completely disrupted. My colleagues at the New Orleans Health Department, 6 months into it, they were still living on a boat. I mean, they had no home. They were trying to do their job but their lives had been completely turned upside down. One of my colleagues was in the Superdome for 5 nights in the same pair of jeans

for the entire 5 nights. And, trying to do her job but she was one of the evacuees essentially and so I think it behooves us not to throw stones because our house is pretty much made of glass.

EV: Were any of these colleagues of yours actually living in the Dome?

HP: Yes.

EV: On a cot with everyone else?

HP: On the cement floor or on a cot. You bet. So, when we talk about the response community, well the response community there was just as affected as everybody else. I mean, nobody was spared. And so, how do you respond when you are part of the disaster? We didn't have to do that here.

EV: A lot of that was like - I cried because I had no shoes, until I met a man who had no feet. It is an eye-opener when you can, even for a nanosecond, put yourself in that position of having everything gone. I was looking at my house. Almost every time I go home after one of these interviews, I think suppose all of this was wiped out and I had to walk out with what I have on? What are my resources? Man! Anything else?

HP: No.

EV: Thank you very much. I will get you a copy of this. If you think of anything you can donate to the archives . . . did you have some photographs that we might be able to borrow from you and we can make copies?

HP: I don't have any printed up, I don't think, but we do have some.

EV: Well, I need to send a reminder to your secretary?

HP: Yes, you will.

EV: Transcriber, this concludes this interview with Dr. Palacio.

INDEX