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NOMINATIONS OF HARVEY E. JOHNSON JR. AND JEFFREY WILLIAM RUNGE

HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

HARVEY E. JOHNSON JR. TO BE DEPUTY ADMINISTRATOR, FEDERAL EMERGENCY MANAGEMENT AGENCY, AND JEFFREY WILLIAM RUNGE TO BE ASSISTANT SECRETARY FOR HEALTH AFFAIRS AND CHIEF MEDICAL OFFICER, U.S. DEPARTMENT OF HOMELAND SECURITY

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NOMINATIONS OF HARVEY E. JOHNSON JR. AND JEFFREY WILLIAM RUNGE

WEDNESDAY, DECEMBER 12, 2007

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:05 a.m., in Room SD–342, Dirksen Senate Office Building, Hon. Joseph I. Lieberman, Chairman of the Committee, presiding.

Present: Senators Lieberman, Levin, Akaka, Pryor, Landrieu, Tester, and Collins.

OPENING STATEMENT OF CHAIRMAN LIEBERMAN

Chairman LIEBERMAN. Good morning. The hearing will come to order.

Today, our Committee will consider the nominations of Admiral Harvey Johnson to be the Deputy Administrator of the Federal Emergency Management Agency and Dr. Jeffrey William Runge to be the Assistant Secretary for Health Affairs and Chief Medical Officer, Department of Homeland Security. Both have been serving at DHS for some time now. We obviously thank them for their service. We welcome them here today, and I particularly want to welcome our friend and colleague, Senator Richard Burr of North Carolina, who will introduce Dr. Runge after the opening statements of Senator Collins and myself.

These are key leadership positions the nominees are being considered for today. They were actually created as part of the Post-Katrina Emergency Management Reform Act, which came out of this Committee and I was proud to work on with Senator Collins. The Act was designed to ensure that FEMA becomes the hub of the Federal Government's efforts to prepare for and respond to disasters of all kinds, whether a natural catastrophe, devastating accident, or terrorist attack, and that DHS has all the tools it needs to protect the homeland and respond to a disaster when it occurs and obviously to do better than FEMA did in response to Hurricane Katrina.

The FEMA Deputy Administrator will have broad responsibility for implementing the Post-Katrina Act and building a new, stronger FEMA, and that is why this nomination is so important. Challenges still face FEMA. There are many. They include leading our Nation's efforts to prepare for the next disaster that we know will come by strengthening FEMA's regional offices, hiring more career senior executives so we institutionalize the change, and continuing

to help citizens in New Orleans and across the Gulf Coast who are still struggling to recover from Hurricanes Katrina and Rita. FEMA must focus on these tasks even as it responds effectively, I am pleased to note by all accounts, to current crises like the recent wildfires which have displaced families in Southern California.

The other nomination we are going to consider today is also critically important to the security of our homeland. Under our Post-Katrina Reform Act, the Chief Medical Officer at DHS is the principal advisor to the Secretary on medical and public health issues. Among the responsibilities of the Chief Medical Officer is coordinating the Federal response to the threat of bioterrorism, which has been a continuing concern of this Committee and I know the Department, ensuring coordination of all medical preparedness and response activities of the Department, and serving as the public face, if you will, of DHS for the State, local, and tribal public health communities. These different elements are not traditionally within the confines of public health but are critically important to effective medical response.

So I would say both of these nominees bring quite significant records of experience with them to this hearing today, so I thank you for offering yourselves for public service in these demanding jobs, both of which include some daunting but critically important challenges that we have to meet if we are going to make our country as safe as we want it to be. I thank you very much and look forward to your testimony.

Now I would yield to Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman. I am going to yield to our colleague, Senator Burr. I know he is on a tight schedule, and I would be happy to have him precede my eloquent opening statement. [Laughter.]

Chairman LIEBERMAN. Thank you. That is very gracious of you.

Senator Burr, we recognize you now for your undoubtedly eloquent introduction.

STATEMENT OF HON. RICHARD BURR, A U.S. SENATOR FROM THE STATE OF NORTH CAROLINA

Senator BURR. Mr. Chairman, I am grateful to you for the recognition, and I am grateful to Senator Collins for yielding to me. It makes me tempted to stay and listen to her opening statement. [Laughter.]

I thank both of you as well as Senator Tester for this opportunity.

Dr. Jeff Runge is before you today as the President's nominee to be the first Assistant Secretary for Health Affairs and Chief Medical Officer of the Department of Homeland Security. The Assistant Secretary for Health Affairs is the Secretary's principal advisor on public health and medical issues with a particular focus on biodefense planning and consequence management. The Office of Health Affairs is the Department's focal point for these matters and ensures health preparedness is integrated throughout the Department's activities.

In the HELP Committee, we have encouraged the Department of Health and Human Services to build preparedness into their mainstream health programs, and it is equally important for DHS to

build health preparedness into their broader homeland security programs.

As you know, the threat of bioterrorism remains. We often think of smallpox and anthrax as the gravest bioterrorism threats. However, as science and technology advance, the number of worrisome agents is expanding. Around the world, radical religious groups are being urged to establish new terror cells that specialize in biological warfare, and it is increasingly easy to access Internet guides to bioterrorism, including methods for contaminating food and water supplies and spreading deadly microbes using do-it-yourself sprayers.

Recently, Hurricanes Katrina and Rita proved once again that Mother Nature can also be extremely disruptive, and the United States is now preparing for a potential flu pandemic that may be carried by birds.

The United States faces a pressing need to continuously improve our public health and medical preparedness and to develop comprehensive end-to-end biodefense plans that enable us to be more flexible and to rapidly respond to all hazards emergencies, be they natural, deliberate, or accidental. In collaboration with the Department of Health and Human Services, the Assistant Secretary for Health Affairs will lead the Nation in these efforts.

Now, I believe that Dr. Runge is the right man for a number of reasons. Mr. Chairman, first and foremost, he is a native North Carolinian.

Chairman LIEBERMAN. That is a good beginning. [Laughter.]

Senator BURR. Lots of good hails from my great State.

Second, he is highly qualified, dedicated, and passionate. Dr. Runge is not only a physician, he has been board certified in emergency medicine. He is also an educator, researcher, as a clinical professor at the University of North Carolina at Chapel Hill and previously at Carolina's Medical Center in Charlotte, one of the busiest trauma centers in North Carolina. He served as the Speaker of the North Carolina Medical Society and the President of the North Carolina College of Emergency Physicians.

As you know, Dr. Runge began his work in Washington in 2001 when he was appointed as the Administrator of the National Highway Traffic Safety Administration. In that job, he emphasized the use of science in setting NHTSA's policy and was a persistent advocate for his priorities. He racked up a long list of accomplishments when he left the job, including the lowest highway fatality rate and the highest safety belt usage in U.S. history.

When Dr. Runge left NHTSA, Secretary Mineta at the time said we are all a little bit safer because of his dedication to the safety cause. Mr. Chairman, I believe we will all be a little bit safer with Dr. Runge at the helm as DHS Assistant Secretary for Health Affairs.

Mr. Chairman, Dr. Runge is a good man. He is a proven leader. He is a skilled physician and I am proud to call him a friend. I hope that my colleagues on this panel will see a need to expedite this confirmation in a way that we can fill the slot in a permanent fashion before we leave this calendar year. I thank the Chairman for his time.

Chairman LIEBERMAN. Thanks, Senator Burr. That is an obviously not only eloquent, but deeply felt statement, clearly. Thanks also, I want to note for the record, for the leadership role you have assumed here in moving our Government to be better prepared to both prevent and respond to a bioterrorist attack. You have done uniquely and singularly important work, and we on this Committee look forward to working with you in the months and years ahead.

Senator Collins.

OPENING STATEMENT OF SENATOR COLLINS

Senator COLLINS. Thank you. Senator Burr, you may leave. [Laughter.]

Mr. Chairman, as you mentioned, the two nominations we are considering today are for positions that Congress specifically authorized last year when we drafted and passed the Post-Katrina Emergency Management Reform Act. That was the law that completely revamped FEMA. This Committee's comprehensive investigation into the flawed response to Hurricane Katrina revealed fundamental problems with our Nation's preparedness for catastrophic disasters. Our decisions to establish the Office of Chief Medical Officer, to elevate this position to the level of Assistant Secretary, and to completely retool the Federal Emergency Management Agency were based on key findings from this Committee's investigation.

We do have two highly qualified nominees before us today. Dr. Jeffrey Runge has been nominated to serve as the Department's primary expert for medical issues related to terrorism and natural disaster, a position that he now holds on an Acting basis. The responsibilities, as Senator Burr has outlined, for this position are indeed significant. They include ensuring the safety of first responders who operate in disaster areas, overseeing the work of the National Biosurveillance Integration Center, coordinating with other Federal departments and agencies on medical and public health matters such as a possible influenza pandemic, and taking action to ensure the security of our food supply, an area where I believe we need to do much more.

I am concerned about the role that the Office of Health Affairs played in conveying timely information about a case of considerable concern to this Committee involving an infected Mexican national who was able to cross our borders several times, and I will be pursuing that issue in my questioning.

I am also particularly interested to hear Dr. Runge's thoughts on achieving full activation of the Biosurveillance Center. In August, the DHS Inspector General reported slow progress on this program, largely due to frequent relocations that undermined management consistency, institutional knowledge, and momentum. Given the considerable danger posed by the threat of bioterrorism, as well as naturally occurring pathogens, I want to learn more about what progress has been made in this area.

Like Dr. Runge, Admiral Harvey Johnson also has an impressive track record for the position for which he has been nominated and in which he is currently serving, again in an Acting capacity. He brings many years of public service in the Coast Guard to this position, and he has presided over significant improvements in FEMA's

performance, for which he deserves significant credit. Unfortunately, as everyone is well aware, he also had the misfortune to preside over a very controversial press conference, and I will be asking him questions about that, as well.

The FEMA Reform Act placed heavy emphasis on qualified leadership for both of these important positions. FEMA needs strong leadership, as does the Office of Health Affairs. I look forward to hearing the two nominees' thoughts on what they have already accomplished in their considerable service and what their plans are.

Thank you, Mr. Chairman.

Chairman LIEBERMAN. Thank you very much, Senator Collins.

We will move now to the nominees. Both have filed responses to a biographical and financial questionnaire, answered pre-hearing questions submitted by the Committee, and both have had their financial statements reviewed by the Office of Government Ethics. Without objection, this information will be made part of the hearing record, with the exception of the financial data, which are on file and available for public inspection in the Committee's offices.

Our Committee rules, as you probably know, require that all witnesses at nomination hearings give their testimony under oath, so Admiral Johnson and Dr. Runge, I will ask you now to please stand and raise your right hand.

Do you swear that the testimony you are about to give to this Committee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. JOHNSON. I do.

Dr. RUNGE. I do.

Chairman LIEBERMAN. Thank you. Please be seated.

Admiral Johnson, we will begin with you. I understand you have family members with you this morning. We welcome them, and I invite you to introduce them and then proceed with your opening statement.

TESTIMONY OF HARVEY E. JOHNSON JR.[1] TO BE DEPUTY ADMINISTRATOR, FEDERAL EMERGENCY MANAGEMENT AGENCY, U.S. DEPARTMENT OF HOMELAND SECURITY

Mr. JOHNSON. Thank you, Mr. Chairman. Thank you, Senator Collins. And thank you, Members of the Committee. I would like to introduce my wife, Janet, who is with me. We just had our 30th anniversary not long ago——

Chairman LIEBERMAN. Congratulations.

Mr. JOHNSON [continuing.] And so she has been a supporter for me in a long Coast Guard career and in FEMA. And my daughter, Jennifer, joins me today. Jennifer is a young professional here in Washington, DC. My son, Scott, is a professional in New York City, and he is working today.

Chairman LIEBERMAN. OK. We welcome both of you and thank you for your support of the Admiral. Please proceed.

Mr. JOHNSON. Thank you, sir. I am honored to come before you today as the President's nominee for the Deputy Administrator of the Federal Emergency Management Agency (FEMA), as reorganized in accordance with the Post-Katrina Emergency Management

[1] The prepared statement of Mr. Johnson appears in the Appendix on page 33.

Reform Act. It has been my distinct privilege to serve over the past 20 months in this capacity alongside FEMA Administrator David Paulison, and I welcome the opportunity to continue my service with him to FEMA and the American people whom we serve. I appreciate the confidence expressed in me by the President and by Secretary Chertoff.

I have already thanked my family, and I just wanted to comment again that life in FEMA and life in Federal service can sometimes be demanding and sometimes unpredictable, but my family does recognize that I have been given a tremendous opportunity to serve our Nation in a position that really makes a difference. My family also understands that service has both its challenges and its rewards, as I have spent close to 38 years in public service.

I have learned almost all that I know about leading individuals and leading organizations by being in the U.S. Coast Guard. That is where I began as an operator aboard a cutter. I transitioned to the cockpit of a helicopter and exercised command from the Operational Command Center. That is where I learned that government really can serve citizens when they most need it and can do it efficiently, effectively, with passion, and with compassion, and that such service can be rewarding beyond measure.

My journey to this hearing began in 1971 as a cadet of the Coast Guard Academy in New London, Connecticut, and continued aboard the Coast Guard Cutter *Steadfast,* where I learned to appreciate the art and the science of seamanship and also the value of leadership and teamwork toward common objectives. I earned my Coast Guard aviator wings in 1977 and piloted Coast Guard helicopters over the next 22 years in the conduct of law enforcement missions and search and rescue, and there I learned to be exacting both in my mental preparation and aeronautical preparation because errors in judgment can be very costly both to me and to my air crew.

I gained invaluable operational experience in a service dedicated to saving lives, protecting the environment, and enforcing the law, and embraced the Coast Guard's core values of honor, respect, and devotion to duty and made them my own. I earned a Masters of Science degree at the Naval Post-Graduate School and another at the Sloan School of Management at the Massachusetts Institute of Technology, and I gained experience in finance and people management, strategic planning, interagency operations, all skills that benefit me now, in my responsibilities at FEMA.

I was honored to be selected to command two air stations, and particularly honored to be selected as a flag officer and then as a manager of the Coast Guard senior leadership team, where we shaped mission performance to measurably affect outcomes. I was selected by the Commandant to lead the Coast Guard's integration into the Department of Homeland Security, and now I work to strengthen the Department from a different perspective.

At the flag level, I commanded the Coast Guard's Seventh District in Miami, Florida, and that is the Coast Guard's most intensive operationally oriented area of operations. As a Vice Admiral, I commanded the Coast Guard's Pacific Area, which is the largest geographic expanse, which includes all Coast Guard missions from the Rocky Mountains west to the Far East, and did both success-

fully as a beneficiary of the dedicated work of Coast Guard men and women.

I describe these extensive operational background and the breadth of leadership experience humbly and without undue pride, not for any self-promotion, but to submit to you that I am both qualified and prepared to accept the responsibilities for which the President has nominated me and for which I ask for your confirmation.

Working with Administrator Paulison, we set a vision for a "New FEMA" that charts a course to become the Nation's preeminent emergency management and preparedness agency. We have established an ethos of leaning forward to provide more effective assistance to disaster victims and to communities, and it is our objective to develop operational core competencies, to strengthen a dedicated workforce, and to foster a business approach to business, and as we do that, every member of FEMA works toward these objectives. Our intent is to better prepare the Nation against the risk of an all hazards disaster and, when that disaster occurs, to marshal a more effective national response and to work more purposefully to speed the recovery of disaster victims and communities.

By establishing the moniker of "New FEMA," we recognize that judgment on our progress would be determined by our actions, not by our words, and so as we have turned our words into actions during this past year, our opportunities for success have been strengthened by three supporting elements: First, a phenomenally dedicated workforce comprised of proud and resourceful professional men and women in FEMA; second, a supportive Congress that has provided the tools we need in the form of legislation and constructive oversight; and third, an operationally oriented and operationally focused President and Secretary who have requested the resources that we need to do our job and have demonstrated confidence in our leadership and our decisionmaking.

Though difficult and challenging to walk beyond the shadow of Hurricane Katrina, that visage is steadily being replaced by a more confident and more competent New FEMA. It was New FEMA that responded to tornadoes in Florida, Georgia, and Alabama, to the Nor'easter in New England, to the wildfires in California, and to the ice storms now gripping the Midwest. Now, to be sure, our success was enhanced by partnerships across the Federal, State, and local jurisdictions, by nongovernmental organizations, and by the private sector, but Mr. Chairman, the leadership was New FEMA.

Mr. Chairman, Senator Collins, and distinguished Members of this Committee, I thank you again for considering my nomination, and if confirmed, I pledge to you that I will continue to work closely with you to achieve the objectives that we both share, and that is to ensure a more safe and secure America. I thank you, and I look forward to responding to your questions.

Chairman LIEBERMAN. Thanks, Admiral Johnson. That was a very strong opening statement. I appreciate it.

Dr. Runge, I gather you have some family with you here today. We welcome them and encourage you to introduce them and then proceed with your statement.

TESTIMONY OF JEFFREY WILLIAM RUNGE[1] TO BE ASSISTANT SECRETARY FOR HEALTH AFFAIRS AND CHIEF MEDICAL OFFICER, U.S. DEPARTMENT OF HOMELAND SECURITY

Dr. RUNGE. My wife, Ginny, is here in the second row. My friend and pastor, the Reverend Ed Miller. My friend of 35 years, Jim Grater, is on the right. My daughter, Emily, is in graduate school in Nashville, and my son, Will, is probably holding down the fort in your home State at Wesleyann University.

Chairman LIEBERMAN. We will try to take care of him while he is there.

Dr. RUNGE. Thank you.

Chairman LIEBERMAN. It is pretty strong to have both your wife and your pastor behind you.

Dr. RUNGE. Well, you never know what is going to come up in these hearings. [Laughter.]

I will be brief. You have my written statement for the record. You also have 56 pages of personal and policy information, so let me just first of all thank you for having this hearing and for authorizing our Office of the Chief Medical Officer in the Post-Katrina Act. I think that is very important for us, for DHS, and for our staff.

I also want to thank my friend, Senator Burr, for his warm introduction, and perhaps most of all to Secretary Chertoff and to President Bush for giving me this opportunity in the form of a nomination.

As Senator Collins said, our Nation is threatened, our citizens are threatened by both acts of aggression by individuals, by groups or foreign states, as well as natural events. The events of the last 6 years within our homeland have spurred many people like me to action who otherwise might have been very comfortable in a profession in the private sector. I have been fortunate to be part of our Department's start-up and maturation. I have witnessed firsthand real leadership and singleness of purpose that I have never seen anywhere, both from Secretary Chertoff and Deputy Secretary Jackson and the incredible professional staff at DHS.

I have also learned a lot from weathering the storms of the challenging merger and the creation of a culture where there once was nothing. Mr. Chairman, the Committee, I know, is very aware of these challenges, and we look forward to your support as we continue to form this "culture of DHS."

I also look forward to finishing the tasks I began as the first Chief Medical Officer of the Department. In that time, we have focused on giving the Secretary, and the Department, medical support for overseeing the health and medical activities in the Department, to lead and coalesce all the Department's biodefense activities that had been helter skelter around the Department, to developing weapons of mass destruction planning and catastrophic incident management, and finally, something that was not in the authorization but which we deem very important, to ensure that the Department's employees, our workforce, are supported by an effective occupational health and workforce protection program.

[1] The prepared statement of Dr. Runge appears in the Appendix on page 133.

We have been successful in attracting some of the top leaders in their fields, including physicians who are trained in emergency medicine, emergency medical services, trauma care, occupational health and safety; veterinarians specializing in animal public health and biological threats; Ph.D.'s trained in biosurveillance and chemical and biological defense; as well as professionals with legal and policy expertise. We have also attracted some of the Department's best up-and-coming administrative and management professionals to assure that we have the infrastructure in place to support our program experts.

Mr. Chairman, building a top-notch career workforce has been my top priority. We have to have a career workforce to protect our Nation during times of transition of political leadership and beyond. This is paramount to our future success.

I am also honored to be here with my friend and colleague, Admiral Johnson, who, with Administrator Paulison, has truly retooled FEMA. The latest responses that FEMA has accomplished are evidence of that, and our office is privileged to support them on all medical and public health matters.

Finally, Mr. Chairman, I look forward to working with your staff on the panoply of issues that we deal with and that come parachuting in, it seems, almost daily. Standing up this capability for the Secretary and the Country has been one of the greatest challenges and rewards of my professional life. I do believe that we are headed in the right direction and are making some tangible progress in defending our homeland. Thank you.

Chairman LIEBERMAN. Thanks, Dr. Runge, for an excellent opening statement.

I am going to start my questioning with the standard questions we ask of all nominees, and I ask that you respond together to each of these questions.

First, is there anything that you are aware of in your background that might present a conflict of interest with the duties of the office to which you have been nominated?

Mr. JOHNSON. No, sir.

Dr. RUNGE. No, sir.

Chairman LIEBERMAN. Second, do you know of anything personal or otherwise that would in any way prevent you from fully and honorably discharging the responsibilities of the office to which you have been nominated?

Mr. JOHNSON. No, sir.

Dr. RUNGE. No, sir.

Chairman LIEBERMAN. And finally, do you agree without reservation to respond to any reasonable summons to appear or to testify before any duly constituted Committee of Congress if you are confirmed?

Mr. JOHNSON. Yes, sir.

Dr. RUNGE. Yes.

Chairman LIEBERMAN. Thank you. We are going to start with a first round of questions of 6 minutes each. I appreciate the fact that we have a good representation of Members of the Committee here today.

Dr. Runge, let me ask you about a controversial case that has engaged the interest of the Committee, and in fact, we are conducting

an investigation. This is the Mexican national with multi-drug-resistant tuberculosis who was allowed to repeatedly enter the United States undetected in April and May of this year after the Centers for Disease Control and Prevention warned U.S. Customs and Border Protection and the Office of Health Affairs that he should be detained at a port of entry. As Chief Medical Officer at DHS, obviously, you had some involvement in this problem.

As I am sure you know, the World Health Organization issued guidelines for reducing the risk of multi-drug-resistant TB on aircraft in 2006. Those guidelines state that individuals with this form of TB should not travel by public air transportation until they have proven to be non-infectious. I will say to you that personally, I always try to approach these difficult situations not so much in a "gotcha" frame of mind, but in terms of what happened and what lessons do we learn as we go forward.

In your response to questions asked by our staff in the pre-hearing interviews on this matter, you responded that neither you nor anyone else at the Office of Health Affairs immediately notified the Transportation Security Administration that the Mexican national could attempt to board an aircraft in the United States while still infectious. In fact, it was not until a month after the office was warned by CDC about this individual and the DHS National Operations Center informed TSA and TSA placed him on a "do not board" list.

So my concern here, and I ask you to reflect on it, is why the Office of Health Affairs did not apparently respond adequately to this incident, and I would ask you in your answer to relate that to the World Health Organization guidelines.

Dr. RUNGE. Thank you, Mr. Chairman. It is going to be difficult to answer this question in 3 minutes and 49 seconds. This is an issue that played out over a period of about 6 weeks. We were first notified at the end of April that there was an issue with someone who was being treated for tuberculosis by Project Juntos, which is a clinic that is operated by the Texas Department of Public Health in Mexico. The axiom of tuberculosis treatment is that patient volunteerism is essential to its success. He was being successfully treated by the physicians in Mexico who were concerned about the possibility of his traveling and had thus notified the Texas Department of Public Health. They subsequently notified the CDC that this gentleman was a businessman and had a business in the United States and was going back and forth, and his doctors advised him at that point not to travel. The Office of Health Affairs was advised of this.

We have two basic functions. One is to support the CDC's Division of Global Migration and Quarantine in their health decisions. The second is to make sure that our components and headquarters are supported in performing those actions.

Now, if you recall, earlier this year, we really didn't have an institution in place, a standard operating procedure, to deal with this at the headquarters level. This was prior to the Andrew Speaker case. We have since developed a Standard Operating Procedure (SOP) to deal with these issues.

By the time this came to headquarters' attention, this gentleman had already been successfully treated, or was being successfully

treated, and probably had an insignificant infection risk. My response at the time when I heard about this was to take his visa, or his border crossing card. I brought this up with the senior management of DHS in our morning meeting, our morning stand-up, at 8:15 and the Deputy Secretary concurred.

We subsequently told the CDC that we wanted the physician to tell him that he had to turn in his border crossing card to authorities, and they talked us out of it. They said, you know what? If we drive people underground and prevent them from going voluntarily to receive TB treatment in this TB-prevalent area south of the border, it is actually going to be worse for public health than if this guy comes across the border under treatment.

Chairman LIEBERMAN. Who made that decision ultimately?

Dr. RUNGE. That decision was made by the CDC's Division of Global Migration and Quarantine.

Chairman LIEBERMAN. Did you agree with it in the end, or did you hold to your initial opinion that the visa should be pulled?

Dr. RUNGE. Well, I actually held to my opinion, although the case is very compelling that if word gets out among the Mexican nationals who are being voluntarily treated here that if they go to the clinic they run the risk of having their border crossing card pulled, it may be worse for public health. And so I yielded to the CDC on this issue. However, this gentleman was still in the "be on the lookout" system for CBP.

It actually wasn't until his physician became more concerned that he (the patient) was actually in violation of his contract not to travel that he reported this back again to the Texas Department of Public Health. They told us about it again. We urged them to find some additional information on this guy, because obviously if we had his right identification, he would not have been allowed to cross.

About a week later, he came in and confessed to his doctor at Project Juntos that, in fact, he was feeling some remorse about this. He saw the negative press that Mr. Speaker was getting in the United States——

Chairman LIEBERMAN. Right.

Dr. RUNGE [continuing]. And voluntarily turned in his border card, and at that point it became apparent that the name that he had given was incomplete, that he had reversed the maternal and paternal last names and so forth, and you know all those details. So at that point, there was no danger of him crossing the border anymore. Moreover, with respect to the flight issue——

Chairman LIEBERMAN. Yes. Tell me about that. As you look back at it, do you think that there should have been an explicit notice that he should not have been allowed on air flights?

Dr. RUNGE. Well, since right about that week, we developed the SOP with TSA——

Chairman LIEBERMAN. Yes.

Dr. RUNGE [continuing]. And found a way to keep them off of planes, not being on a terrorist watch list, which the Department of Justice is very loath to do—put somebody on a terrorist watch list.

Chairman LIEBERMAN. So now there is a procedure in place that would keep them off of an aircraft?

Dr. RUNGE. Yes, sir.

Chairman LIEBERMAN. My staff apparently has been having some trouble, I don't believe with you, with the Department in getting a copy—to our staff—of the standard operating procedure. Would you commit to us this morning that you will get those to us as soon as possible?

Dr. RUNGE. Absolutely, and——

Chairman LIEBERMAN. It is in effect now, I take it?

Dr. RUNGE. Yes. We have been using it since June. I sent a flow diagram over to your staff. The SOP actually needs to be signed off by the head of our Operations Coordination Directorate.

Chairman LIEBERMAN. OK. I will tell you I am not an expert at this, but I think your original judgment was right and that they should have pulled his visa, even though I understand there is an argument on the other side. It is not clear, absolutely right or absolutely wrong, but I think the predominance of common sense was on your side on that original judgment. I thank you.

Senator Collins.

Senator COLLINS. Thank you. Admiral Johnson, I want to talk to you first about the press conference that you held on October 23 in order to inform the press about FEMA's response to the California wildfires. Because FEMA gave very short notice to the members of the press about this press conference, there were, in fact, no reporters present at the press conference. Some were listening by phone, but there were no journalists in the room. You proceeded to take several questions from departmental employees who were posing essentially as reporters.

Now, what I want to do is to ask you a series of questions so that we can better understand the state of your knowledge when you learned certain vital information and exactly what happened.

First, did you learn prior to going into the press conference that there were no journalists present?

Mr. JOHNSON. No, ma'am. As I entered the press conference, it was my understanding at that time that there were media that would be present in the press room for the briefing.

Senator COLLINS. During the press conference, did you realize that there were no members of the press actually present?

Mr. JOHNSON. No, ma'am. In the press room, and people have seen different pictures of the press room, one picture accurately reflects people that I knew that were members of my immediate staff and part of the staff that I engage with routinely. The picture doesn't show the right-hand side of the room, which had a number of people, perhaps six to eight people, who were dressed casually, in my view. I did not know them personally, and they looked as if they could have been media that I would typically engage in a press interview. So when I entered the room and looked at who was in front of me, it looked to me like I was seeing people that I did not know, and I presumed they were members of the press.

Senator COLLINS. When did you actually learn that members of the press were not present?

Mr. JOHNSON. Well, that news conference took place on a Tuesday, and the first indication I had that we had made a serious mistake was on a Thursday when I received an e-mail from a *Washington Post* reporter indicating he wanted to ask some questions

about that interview. So it really wasn't my knowledge from Tuesday through Thursday that the room was filled with members of the FEMA staff.

Senator COLLINS. So until a reporter e-mailed you and asked you about this press conference, you had no realization that the press conference was not a legitimate, typical, authentic press conference——

Mr. JOHNSON. Yes, ma'am——

Senator COLLINS. Is that correct?

Mr. JOHNSON. Yes, ma'am, that is correct. If I may——

Senator COLLINS. Yes.

Mr. JOHNSON [continuing]. I would like to offer a couple comments that might be helpful, as well. First, I——

Senator COLLINS. Let me just ask one question and then I will let you explain.

Mr. JOHNSON. Yes, ma'am.

Senator COLLINS. Just to complete this, did you in any way direct FEMA to stage this press conference?

Mr. JOHNSON. No, ma'am.

Senator COLLINS. So you went into the press conference assuming that these were reporters. You answered questions assuming that these were reporters. And it was only when you were contacted by the *Washington Post* 2 days after the press conference that you realized what had happened?

Mr. JOHNSON. Yes, ma'am, that is correct, and let me just——

Senator COLLINS. Then go ahead.

Mr. JOHNSON [continuing.] Be pointed. As I was taking questions, I certainly knew that the questions that were asked by people I knew from FEMA were from FEMA, and I will talk about it in just a second. And then the last question that was asked was by a person who I did not know who was from FEMA, but I did not know at the time, and who I presumed was a member of the press.

If I can make a couple comments. First, I want to acknowledge that I am the Acting Deputy Administrator of FEMA, Chief Operating Officer of FEMA, and what goes on inside that agency in large part is a shared responsibility between me and David Paulison. I was the senior person present at that news conference, and so that news conference and the content of that conference was my responsibility, and I don't walk away from that.

I issued an apology the morning after I became aware of the circumstances of that news conference, and with David Paulison, at his direction and with my support, we have taken significant actions to ensure that event does not occur again.

The second point I would like to make is that this news conference is extremely regrettable, and I know that you regret it as a Committee because of your investment in FEMA, but I have to tell you that personally, I talked to you about my 38 years in public service. I talked to you about core values that I have embraced as my core values, and the end result of that news conference was in conflict with my core values, and so I personally regret that news conference.

From a professional perspective, that is not how we want to do business in New FEMA, and we talk a lot about New FEMA, and

that news conference has cast a shadow on that, and so I regret it from that perspective.

And perhaps the third perspective is that if we talk about New FEMA and we want New FEMA to be reflected in our actions, we demonstrated New FEMA in California wildfires, and with our partners in the State, we did a phenomenal job in responding to a disaster on very short notice, and I regret that the news conference cast a shadow on that performance, as well.

The third comment I would like to make is it is repairable. At Dave Paulison's direction, we have taken a number of actions. We brought a respected member of the news media in to meet with our public affairs staff just to hold a session on ethics and media.

I don't recall the exact name, I apologize to the association, but we have gone to a public affairs association, and they came in and I was a part of, a short part of this session. But they came in and spent a complete afternoon in an iterate back-and-forth presentation with all of our staff, including those in the regions that participated by video conference, on a little bit of ethics in journalism, but really professionalism in journalism.

In FEMA, of all the many things we do right, one that we don't do well is invest in our people, and Dave Paulison is going to fix that, but we are about right now investing in the professionalism of our public affairs staff. They are good people, and this was an unfortunate sum of a series of bad decisions. No one on that staff intended or planned to have the news conference turn out the way it did. Everyone who was involved in that process made decisions at the time that they thought would have provided good information to the public, responsive to questions we had received from the media, and again, I think from me to everyone involved, there is just sincere regret for that occurrence.

Senator COLLINS. Thank you.

Chairman LIEBERMAN. Thank you, Senator Collins. Senator Tester, good morning.

OPENING STATEMENT OF SENATOR TESTER

Senator TESTER. Good morning, Mr. Chairman. Thank you very much. The standard operating procedure—and again I can't speak for the rest of the Committee—but I would love to see it, too.

Chairman LIEBERMAN. Yes, absolutely. It is real important. Dr. Runge, if you can do that later today, it would mean a lot to the Committee.

Dr. RUNGE. I certainly will. Actually, I did send this flow diagram over to your staff on Monday. This is not the written standard operating procedure (SOP).

Chairman LIEBERMAN. Good. Thank you.

Senator TESTER. Yes, thank you, and I am going to follow up on some of Senator Collins's questions in regard to the news conference, too. So when you entered this news conference, were there folks who you knew that were from FEMA that were asking questions?

Mr. JOHNSON. Yes, sir. As may be the case with your press conference, when I entered the room, my staff was with me, and so we entered the room from two separate angles. I walked into our press room, which some of your staff have been in, and I was at

the podium, and then my staff came in and took these front seats, as you perhaps have seen in the picture. Already in the room were another perhaps six to eight to ten people who turned out to be FEMA employees.

Senator TESTER. And they were the folks that were doing the questioning of you, the FEMA employees, so you knew that they were FEMA employees, with the exception of one person?

Mr. JOHNSON. As they began to ask questions, again, looking back, six questions asked, the first five by people who I knew from my staff——

Senator TESTER. Didn't you find that a bit odd?

Mr. JOHNSON. As those questions were being asked, it was odd that a member of my staff would be asking me a question. As those questions occurred one at a time, I fully expected that the following question would come from a member of what I thought was the news media——

Senator TESTER. OK.

Mr. JOHNSON [continuing.] And those played out that way, one at a time.

Senator TESTER. You have already expressed through Senator Collins's questions that this went against your core values, and you do have a very impressive resume with accomplishments and awards. You also said there was a series of bad decisions. I think Secretary Chertoff called this one of the dumbest and most inappropriate things he has ever seen since he has been in government. I think you agreed with that assessment.

Do you know who initiated the press conference?

Mr. JOHNSON. The press conference was initiated by our Director of External Affairs, Pat Philbin.

Senator TESTER. Is he still with the agency?

Mr. JOHNSON. He is not.

Senator TESTER. Was he retired because of this incident?

Mr. JOHNSON. He had already submitted his resignation from FEMA and was en route to a follow-on assignment in government, and so actually, this news conference was on a Tuesday and his last day in FEMA was scheduled to be on Friday.

Senator TESTER. And he was singularly responsible for the incident?

Mr. JOHNSON. Within the Directorate of External Affairs, it was his responsibility to organize and arrange the press conference. He was assisted by a number of members of his staff, but that was his primary responsibility.

Senator TESTER. We have all been involved with press conferences in the positions we are in on a regular basis, and I can tell you if I had a press conference and I walked in and my staff was asking me one question, red flags would go up. The question is that your resume indicates you are a leader. Your history of 38 years in public service indicates that you are a leader. Why didn't you just say, hold it. What is going on?

Mr. JOHNSON. Well, sir, in retrospect, there are a number of places where we could have changed and altered the course of that press conference and yet accomplished our task. I have certainly gone over in my mind a number of times the actions that I could

have taken that could have changed the course of that press conference.

Senator TESTER. OK. One of your bosses, Robert Jamison, was in here a bit ago, and he had some trouble with contract employees responding to some of the questions, and that was an issue that this Committee took up. I just want to get your perspective on FEMA's reliance on contractors, not necessarily in an emergency situation but in day-to-day operation of the agency. What is your perspective? How do you feel about contractors?

Mr. JOHNSON. I think that it may surprise you or others that there are only 2,300 permanent full-time members of FEMA. That is smaller than most junior high schools in America.

Senator TESTER. Out of how many total?

Mr. JOHNSON. Out of America?

Senator TESTER. No, out of what is in the agency including the contractors.

Mr. JOHNSON. There are close to 3,000 FEMA permanent employees. There are about 8,500 temporary FEMA employees that come in the form of what we call core employees or disaster assistance employees, and those allow us to have perhaps a less user reliance on contractors than perhaps some agencies. We currently have badged into FEMA across our agency close to 2,500 contract employees, and those are stretched not just in headquarters, but across all of our agency.

Senator TESTER. Are you happy with that situation versus full-time employees?

Mr. JOHNSON. Well, certainly when the President's budget is approved, we will grow by 250 full-time employees, and that will allow us to decrease our number of contractors.

Senator TESTER. I just want your perspective on the contractors.

Mr. JOHNSON. I think that FEMA appropriately employs contractors to do the right types of work.

Senator TESTER. OK.

Mr. JOHNSON. We have some flexibilities that other agencies don't have and so that gives us a greater latitude to do that.

Senator TESTER. OK. We will have another round of questions, so I will forego the last 45 seconds.

Chairman LIEBERMAN. Thanks, Senator Tester. Senator Akaka, you are next.

OPENING STATEMENT OF SENATOR AKAKA

Senator AKAKA. Thank you very much, Mr. Chairman.

Admiral Johnson, let me ask you about something that is closer to the Pacific and really about Hawaii. You have spoken about your plans to enhance the role of the FEMA regional offices and to place people in those offices to help States deal with the grant application process. For me, this is a welcome initiative. I think that FEMA over time has had so many problems and many of them, as we have found out through the hearings that we have had, have been those of personnel, so we really need to work on that.

As a former Pacific Area Commander in the U.S. Coast Guard, you are well aware of the unique challenges faced by Hawaii and its role in providing support to Pacific Rim countries and U.S. Territories in the region. For that reason, I have long advocated a

FEMA Regional Office in Hawaii and would like to discuss further with you that possibility.

In your role as Deputy Administrator, would you commit to reviewing Hawaii's special needs and the Pacific's special needs and report back to me on the viability of establishing a FEMA Regional Office for Hawaii?

Mr. JOHNSON. Senator Akaka, I would be very pleased to do that. I have spent 2 years as Commander of the Coast Guard's Pacific Area. I spent a number of times in Hawaii, and then through Hawaii to the same locations that you speak of, out to Guam and to Micronesia, and certainly places even further. I have watched Nancy Ward, who was our Regional Administrator in Alameda Region IX, work very well with our area office established in Hawaii and I think that you make a strong point about the size of the FEMA presence. I would be very pleased to look at that again and discuss that with your staff.

Senator AKAKA. Thank you, Admiral.

Dr. Runge, can you tell me the status of the National Biosurveillance Integration Center, we know it as NBIC, and what your goals for NBIC over the next year or two will be?

Dr. RUNGE. Senator Akaka, first of all, I want to thank the Congress for actually providing the National Biosurveillance Integration Center with a specific authorization in the 9/11 Act. It is also very important to institutionalize this function.

This was an idea that was generated partially over here in the Senate and partially in the White House. This was supposed to be a neutual ground where biosurveillance information on human health, animal health, food, water, and the environment could all be shared and then put into what we call a biological common operating picture so that everyone who has a duty around biosurveillance or bioprotection would have access to the same information as everyone else. That currently does not exist and has never existed across the Federal Government or the private sector.

This program was first funded in 2004, and frankly, because there were other priorities in the office where it was located, it languished. And some people were leading the program that had ideas about making it an intelligence community function and so forth, which really was not compatible with our vision of an open source biological common operating picture.

We assumed responsibility for that program a little over a year ago. We assumed it with its legacy budget, but no Federal FTEs. Not one FTE was brought over with the program to the Office of Health Affairs. Since we were at that time a group of about eight or nine people, we didn't have FTEs to devote to the program, but I did send over my Chief Scientist to turn that program around and to get it back on track, to reach out to HHS, to CDC, to Interior, to State, to DOT and others to bring them into the dance.

Our program depends—and this is where I am heading this year—our program is not so much about the system or the IT system, it is about the people. The people make the Center. And it is about a group of smart people sitting around the table who have access to their own data in their specific areas who are able to look at it, contribute to an analysis, and then put it up there so that everybody can see the biological common operating picture.

The good news is that we do have an IT system that should be up and running in January that will be a platform for this information to exist and to actually come up on the screens of anyone who has the authority to look at it. It could come up in the Chairman's office here. It could come up anywhere. What we lack now is actually getting the people in the chairs. We are in the middle of the interagency agreements necessary to do that. Our intention is to fund those positions for the agencies so we are not dependent on their charity to actually stand up this Center. We are in the budget discussions about how to do that, but we think it is very important to get long-term detailees who will be trained in analytics and will know each other and will know the data within their own centers.

Senator AKAKA. My question will take me a little longer, but let me say that I appreciate the authorization of NBIC in the 9/11 bill having to do with a common biological operating picture and I was very pleased to hear that your office has been working with the International Species Information System on its veterinary record-keeping system called ZIMS as an input to NBIC. I would like to ask you for information about what the status of those discussions is and ask you to do it for the record because of time here.

Dr. RUNGE. We will, Senator Akaka. Thank you very much. There is a predominant problem and that is that there are many data systems that we would like to have access to, but they are expensive. And frankly, if we have to pay $1 million to ARGUS or $1 million to ZIMS, pretty soon our $8 million budget is gone. So we need to be able to figure out how to get over the hurdle of having to pay for those data.

Senator AKAKA. Thank you. Thank you very much, Mr. Chairman.

Chairman LIEBERMAN. Thanks, Senator Akaka.

For the information of my colleagues, in order of appearance, and in order of seniority, Senator Levin, Senator Landrieu, and Senator Pryor, although in order of age, clearly Senator Landrieu is the youngest.

OPENING STATEMENT OF SENATOR LEVIN

Senator LEVIN. I will trade places with Senator Landrieu. I would be happy to switch age if you can. [Laughter.]

Thank you, Mr. Chairman.

First, on the question of the formaldehyde-contaminated trailers, Admiral, let me ask you this question. You have stated that the testing by FEMA of occupied trailer units has not yet begun, and I am trying to figure out why.

Mr. JOHNSON. Fortunately, Senator, we are working with CDC, and Dr. Runge is a very strong partner over months of dealing with this issue, but CDC was able to sign a contract and announce that yesterday and there were briefs to some of the staff and there will be briefs this afternoon that indicate that we will be able to begin testing by December 21. And so we will test 500 occupied travel trailers—these will be 250 in Louisiana and 250 in Mississippi—as part of a scientific statistically significant test that will allow us to generalize the results of those tests across the 50,000-some-odd travel trailers now occupied by those who were impacted by Hurricanes Katrina and Rita.

Senator LEVIN. What has taken so long, and what is the purpose of the test? Are you trying to determine what the level of formaldehyde is?

Mr. JOHNSON. That is correct, sir.

Senator LEVIN. Why has that taken so long?

Mr. JOHNSON. It has taken a long time in part because we have not had this problem before. In the past, in other disasters, we had people who resided as disaster victims in the travel trailers for very short periods of time. This is the first time we have had people in travel trailers for this length of time, up to 2 years, in which case some of these symptoms and the impacts on health have become more apparent. And so in part, quite frankly, it is a recognition on our part of the significance of the situation.

Once we recognized that, and I certainly acknowledge that we could have, in hindsight, recognized that sooner, the desire is to go about it in a scientific way so that we, in fact, can ensure ourselves that we understand the full implications both now and into the future, both for the housing program and for the individuals who are involved. And so there are some significant health issues that Dr. Runge can speak of, but I will tell you that from an operational perspective, it took us a while to get a contract in place, which we had in place in October, and then we found that our actual ability to conduct a test, we had that locked and loaded, ready to go, but it was ahead of our ability to interpret the results. And so that if we could go into a trailer and provide someone with a reading of the level of formaldehyde, it is most important to be able to describe to that person what that result means so they can, in fact, make good decisions about whether or not they should stay in that trailer.

Senator LEVIN. Why can't that be done with a brochure? This has been going on now since April 2006, when the testing began by the Sierra Club. In July 2006, there was a confirmation story about the levels of formaldehyde. In July 2006, another confirmation story. I don't understand why it takes so long to hire a contractor to determine the level.

And I am going to leave it at that because I don't want to spend all my time on this issue. However, it seems totally unacceptable to me that it takes FEMA all this time to do a test on trailers which were known to FEMA a year and a half ago to contain unacceptable levels of formaldehyde. I was very troubled by David Paulison's statement in May that formaldehyde does not present a health hazard. I don't know who told him that. Doctor, do you know whether formaldehyde poses a health hazard or not?

Dr. RUNGE. Well, Senator Levin, there is certainly no direct linkage to the thing that we worry most about, which is long-term cancer——

Senator LEVIN. Does it pose a health hazard or not?

Dr. RUNGE. It does present some hazards to people's health who are sensitive to formaldehyde.

Senator LEVIN. Is that a yes?

Dr. RUNGE. It is not a yes/no answer.

Senator LEVIN. So in other words, to some people it presents a health hazard?

Dr. RUNGE. To some people, it presents an immediate health hazard because of sensitivity.

Senator LEVIN. And what about to other people? Might it present a health hazard to those who do not have an immediate problem?

Dr. RUNGE. We are waiting for the National Cancer Institute to bring forth the study which is due this fall to determine whether there is an actual link——

Senator LEVIN. In the meantime, we could have determined the level of formaldehyde in those trailers. That testing could have been done——

Dr. RUNGE. Well, the problem is why we are waiting——

Senator LEVIN. You are planning to test 500 trailers out of how many total trailers?

Mr. JOHNSON. There are 50,000 travel trailers across the country, and it is important to conduct this test in a way that we can test 500 then legitimately generalize across the rest of the those travel trailers.

Senator LEVIN. Let me move to another subject. Dr. Runge, would you add a vaccine category to the standardized equipment list and authorized equipment list that you folks use? Is there an easy answer to that?

Dr. RUNGE. There is a process for doing so, and we have engaged in that process. I think I know where you are going with this.

Senator LEVIN. That is underway?

Dr. RUNGE. Yes.

Senator LEVIN. The process? OK. That is great.

There have been some questions asked, Admiral, about contracting already, but my question is a little bit different. It has to do with the Post-Katrina Emergency Management Act that was signed into law over a year ago, which required that DHS promulgate regulations to ensure that contracting agencies limit the excessive use of subcontractors by contractors and regulations that would limit the length of time a disaster-related contract may remain active when it is awarded non-competitively. Those regulations have not been issued. Why?

Mr. JOHNSON. The regulations themselves require some study by the Federal Standards Board, and that process is in motion. While that process is in motion, sir, we are taking a number of steps inside FEMA to comply with the requirements of the law in advance of the regulations being issued.

Senator LEVIN. Wasn't there a requirement that the regulations be issued by October?

Mr. JOHNSON. Yes, sir, there was a requirement.

Senator LEVIN. Was that requirement met?

Mr. JOHNSON. No, sir, it has not been met.

Senator LEVIN. Why?

Mr. JOHNSON. It is not totally FEMA's responsibility to issue those regulations. I am not quite sure of the long delay. In FEMA, what we are looking at is the intent of those regulations and how we can begin to comply with it even in advance of the regulation being issued.

Senator LEVIN. Well, you haven't complied with an important part of the law which requires that the regulations be adopted within a year. That, you have not complied with. And it seems to

me when we pass a law, that you folks ought to comply with it, and a year is plenty of time. So let me express my dissatisfaction on that count, too.

My time is up. Our expert on Hurricane Katrina is to my right, and she is younger. She has been very patient waiting for her senior colleague age-wise to ask questions.

Chairman LIEBERMAN. That would be Senator Landrieu you are speaking of?

Senator LANDRIEU. You are doing so well, go right on. That is a great line of questioning.

Senator LEVIN. I am over my time. Thank you.

Chairman LIEBERMAN. Senator Landrieu.

OPENING STATEMENT OF SENATOR LANDRIEU

Senator LANDRIEU. I thank you, and let me begin by thanking my colleagues, particularly Senator Collins, Senator Levin, and Senator Tester, for addressing several of the issues that I had on my agenda to discuss with you all, particularly the press conference, which was very troubling to many people in the country, particularly the people along the Gulf Coast that are still, as you know, struggling to rebuild. I think that has been covered.

The trailer issue is another issue that I really appreciate the Senators focusing on because, Dr. Runge, I don't have to tell you how concerned people are along the Gulf Coast, over 50,000 families, maybe 150,000 people, three people per trailer, and as you know, these are small trailers. Some of them have six people living in them. I pass them all the time when I am home, and when it is cold, most of the time the windows are closed and the doors are locked, and of course, your Department has issued rulings that the only time you have a problem is if the trailers are locked up. Well, in cold weather, people don't leave their doors and windows open.

So I am pleased. Senator Stevens and I sent a letter to FEMA urging them to resume testing. You have testified today, Admiral Johnson, that testing will now proceed. I am very happy to hear that, and we will deal with the results. I hope FEMA, HUD, and this Administration are ready to deal with the results. If these trailers are found to be dangerous and people should not be living in them, then this government is required to come up with an alternate plan for people to find more long-term comfortable arrangements.

Now, I want to say something and then I have a few questions. I wanted to first of all thank you both for your willingness to serve. I particularly want, Admiral Johnson, for you to know that of all the agencies, the Coast Guard most certainly distinguished itself during our time of need. The people of Louisiana and New Orleans, as you know, there were over 1,200 people that died mostly by drowning. A lot more people would have died if it hadn't been for the Coast Guard, and I appreciate the service that you have given to our country for 38 years. Please give my best to the leaders of the Coast Guard.

But I want to make it clear to this Committee and to the Chairman and Ranking Member that I am not prepared to support either nomination at this point—I am sure we will not be voting

today—until I am confident that you all are both the agents of change that you claim to be.

I am pleased to hear you speak about a New FEMA because the country desperately deserves one. The one that we have now is not ready, despite the efforts of the good leaders of this Committee, to handle a catastrophic disaster, and we need to be ready in the event that this happens sooner rather than later. It will happen again. It is just a matter of time.

So I want to say that I am going to be listening very carefully to your answers to our questions and comments, and again, I want to be part of helping to build a New FEMA. Your appointments are very important because you signal whether this Committee is serious about approving nominees that are truly agents of change or just continuing business as usual, and this Senator is not going to support business as usual.

Admiral Johnson, you have, I think, explained the press conference. I think you have talked about trailers. But there is right now pending a request of mine before FEMA which Chairman Paulison has indicated that he is indeed supportive of, but we have been unable to execute, and that is a pilot initiative to try to process more quickly project work order sheets, which is the way you do your business, as you know, trying to replace schools, hospitals, libraries, fire houses, and police stations. In this instance, it is schools.

In the parishes that I represent, in a catastrophic disaster where 250,000 homes were destroyed, unlike California where only 1,600 homes were burned, in our situation, 250,000, there were a majority of schools in certain parishes—Orleans, Plaquemines, and Cameron—that were destroyed.

Mr. JOHNSON. Right.

Senator LANDRIEU. And we are still having difficulty 2½ years later, after billions have been spent by this Congress to help children find classrooms all over America. Do you know, Mr. Chairman, we are still having problems processing a solution to this. This Chairman and Ranking Member have approved a solution. Are you aware of what we are promoting? Are you supportive of it? And are you willing to at least try to pilot a global solution of reimbursement for schools for the parishes and counties that were devastated, and would you consider using this pilot to try to expedite the rebuilding of public facilities in the future?

Mr. JOHNSON. Thank you for your question. You are an active Member of the Senate, an active Member of this Committee, and an active Member in helping to bring about New FEMA. And so from Dave Paulison and from others, we appreciate your personal interest and your persistence on a number of issues, one of those being schools.

As you know, we work with Dr. Pastorek. We changed a lot of our approaches in FEMA and the use of Stafford and, for example, the alternative project. We have approached that in a way, with your urgings, that allows the district to take money that would have been given for the damage to any one school and to bundle that money together then and to use that with good decision-making to build the right schools in the right location that provides

the capability those children deserve. And I think that is the thrust of your initiative.

Senator LANDRIEU. So are you testifying that you are supportive of that new approach that has been approved by this Committee and are willing to push it through?

Mr. JOHNSON. Absolutely. One of our highest agenda items of all the PWs is to focus on education, and I think we have done that with your urging, and I think that we have got some good results with the State to show for that.

Senator LANDRIEU. OK. I know my time is short. I would like just another minute. I would like to submit to the record, Mr. Chairman and Ranking Member, a survey that actually just came out yesterday that was conducted by the University of New Orleans,[1] and I would like it submitted to this Committee's record. I will point out in this that we have a long way to go because there is some good news and bad news in this survey. The bad news for FEMA is that over 80 percent of the people surveyed nationwide have a very negative impression of the leadership under Michael Brown, and they are not that familiar with the new leadership. In their mind, it is the same old FEMA and they don't like it and they want it changed.

The other interesting information about this survey is that over 62 percent of the people around the country are willing to do more. Despite the fact that over $110 billion has been spent, Mr. Chairman, this survey indicates that people are willing to do more because they recognize that it was the Federal Government primarily that failed, along with some failures, of course, at the State and local level.

There are some very interesting data. I think you will find it helpful to you as you build the New FEMA, or as you are nominated to build the New FEMA, and I just wanted to submit that for the record.

I have several other questions, but my time is over. Mr. Chairman, I would like to submit them for the record and then I will be in touch with you all personally again. I appreciate your willingness to serve, but my vote will hinge solely on whether you both are agents of change or whether you are just there to continue the status quo. Thank you very much.

Chairman LIEBERMAN. Thanks, Senator Landrieu. Senator Pryor, aged as you are. [Laughter.]

OPENING STATEMENT OF SENATOR PRYOR

Senator PRYOR. Thank you, Mr. Chairman. I am aged—anyway, we will talk about that later. [Laughter.]

I want to thank both of the witnesses today for coming in and visiting with me in my office. I appreciate your time and your commitment to public service. I mean that.

Let me, if I may, focus on you, Mr. Johnson, because there are three or four areas I want to cover very quickly. I will try to be very brief, but one is a follow-up to Senator Levin's questions. There was a theme in his questions, and I have heard the theme

[1] The survey by the University of New Orleans submitted by Sen. Landrieu appears in the Appendix on page 244.

with other Senators. Quite frankly, I have been on this Committee for 5 years now and I have heard it pretty consistently with FEMA for 5 years, and that is how long it takes for FEMA to get done whatever it is supposed to do.

Just today, Senator Levin asked about formaldehyde and trying to figure all that out and why it has taken so long, the contracting regulations, why it has taken so long, the trailer issue generally, and why it has taken so long. Yesterday in our office, we talked about an interim report, and I appreciate receiving it. I understand it is interim and it is not the final report, but we have been in contact, either my office or the Subcommittee, have been in contact with FEMA since February on that, and they told us it would be ready in March, and here we are in December and just got it.

Are you committed and have you thought about ways to shorten the time tables in FEMA? It will take a management decision on your part and other people's part to try to shorten the time table, try to cut through the red tape, and get things turned around more quickly. Is that possible?

Mr. JOHNSON. Thank you for your question, Senator Pryor. I believe it is possible, but I would like to point out, though, that the same people that are working on New Madrid plan are the same people who are running the National Response Coordination Center today for the snow storms and the ice storms in Oklahoma, and the same people that are planning the hurricane planning for the following year, and the same people that are involved in running day-to-day operations. And so in large part, as I mentioned to Senator Tester's question, the size of FEMA is sometimes an inhibitor in our making progress on those reports.

And so we are committed to that. We do track that. We just are implementing a new system, which we never had before, that electronically tracks our progress on reports, and we are able to prioritize and get those things that must be done quicker. So I think it is a good observation, and we are working on that, sir.

Senator PRYOR. Yes. My experience is, and again, I have never run an agency that size, but when I was the Attorney General of my State, we had an Attorney General opinion function, which Senator Lieberman and I have talked about before because it is a trap for a lot of AGs out there, but nonetheless the average turnaround time before I came was over 50 days, where a State agency would write for an opinion and it would take us over 50 days to respond. I don't think anyone ought to wait 50 days to hear back from his or her lawyer, so we shortened that time and made sure that we got it down to around 20 days.

It took a commitment from the top and folks down the line to make sure it got done. In that situation, a lot of things would get on people's desks and just sit there. However, if you give employees a deadline and force them to turnaround the work, they will do it and you never develop the backlog. So I am not trying to tell you how to run your agency, but I do think that one of the sources of frustration with FEMA in the Congress, and the Senate, and this Committee has been the slow turnaround time on a number of fronts.

The other thing I just wanted to mention is that I think it is very important for FEMA to work—I would love to say seamlessly, I

don't know if that is a realistic statement—but I would love for FEMA to work very well with State and local and also the private sector. We talked about that a little bit yesterday. But the private sector is very good at responding to disasters and planning, staging, and preparing for disasters because their business rests on that. I think there are lessons that FEMA can learn from the private sector. Obviously not all of it transfers, but I also think that partnering with the private sector in many ways makes sense for FEMA and the Federal Government. Do you have any comments on that?

Mr. JOHNSON. I think your point is well taken. FEMA established not long ago our first Loaned Executive—we have a Loaned Executive Program. We established one. And we actually have an executive from UPS who works inside FEMA's Logistics Directorate for that intent purpose, to reach out into those industries that represent core capabilities within FEMA and to bring those lessons inside FEMA.

We just recently established our own Private Sector Office to begin to reach out further into the private sector community. So I think you make an excellent point and that should be part of New FEMA, a characterization of New FEMA, that we do establish stronger relationships and draw on those lessons learned from the private sector.

Senator PRYOR. Great. The last thing I wanted to say is that—and this is as much for my colleagues as for you—yesterday we talked about a bill I had filed about the trailers and mobile homes and trying to put that on a time table for, first, FEMA to figure out exactly how many you need to have in reserve and be able to have those when you need them, and then, second, to move the ones you don't need out and then report back to Congress, etc. So I appreciate your looking at that legislation. I would love to circulate that among the Committee and among the Senate to let everybody look at it and see if it makes sense, but thank you for working with us on that.

Mr. JOHNSON. Yes, sir.

Senator PRYOR. Thank you, Mr. Chairman.

Chairman LIEBERMAN. Thanks very much, Senator Pryor, and I look forward to working with you on that legislation, as well.

Dr. Runge, let me come back to bioterrorism and ask you as if I were a layman, which is we are all worried about the threat of bioterrorism, and the question would be, which people ask me as I go around, are we prepared for it? What is the state of our preparedness to both prevent and then, of course, respond to the threat of bioterrorism? So I know this is a main focus of your work. I know you don't have a lot of time to answer it, but give me your best quick answer on that.

Dr. RUNGE. Mr. Chairman, we are infinitely better prepared than we were even 2 years ago or 3 years ago, and it has to do with the work not only of DHS, but with many partner agencies.

Chairman LIEBERMAN. So cite a few specifics of what has happened in the last couple of years.

Dr. RUNGE. Well, for instance, we have set up a bioforensics capability through our NBACC program at DHS which affords the Department of Justice a chance to do rapid characterization of the

genomes of agents of bioterror. The catastrophic scenario that we talk about with anthrax, for instance, is horrible, but it is even more horrible when you consider that there could be second, third, and fourth attacks. It is very important to get the forensic signatures on these to allow the Department of Justice and those who operate internationally to try to prevent those secondary attacks.

The Department of State is very active in counterproliferation activities, both in the bio as well as the nuclear world. Clearly HHS is working very hard at developing human medical countermeasures in the event that prevention and protection are not successful.

Chairman LIEBERMAN. Talk to me a little bit about what the condition of our public health infrastructure is to respond to a bioterrorist attack. I mean, obviously, the kind of attack we fear is where an agent is released and it is of a contagious illness and it begins to spread, or it is a naturally occurring illness that assumes epidemic or pandemic proportions, presents similarly. Are we prepared for that surge in demand on our public health system?

Dr. RUNGE. I would offer that this is more about the public's health than about public health in a conventional sense. The Public Health System in the United States atrophied for decades, particularly in the latter part of the last century. There was an infusion of cash and energy provided by the Congress to the Public Health System in the form of the supplemental funds for pandemic influenza. However, we can't rely on the public sector to provide for people's care in the event of either a natural or manmade health problem. This is a problem that we all have, and 99 percent or more of health care in this Country is delivered by the private sector. Until we have weaved them into the fabric of preparedness, we are not going to be truly prepared to manage those consequences.

Chairman LIEBERMAN. Is it clear within the Department what your role as principal advisor to the Secretary on public health would be in the case of a catastrophic bioterrorist attack?

Dr. RUNGE. Yes, sir. We have a very small office, but job one was making sure that both the Secretary and those who have to respond, like FEMA, are supported by the best medical and public health advice possible. In so doing, we have been through several exercises looking at roles and responsibilities around the Department, and clearly if it is human health, HHS runs the Emergency Support Function 8, which is part of the Emergency Support Function structure. They are responsible for delivering health care to the population. And the Secretary of HHS is responsible for that function.

Secretary Chertoff, however, has overall responsibility under HSPD–5 (Management of Domestic Incidents). We are his agents in ensuring that all of those elements are, in fact, occurring and that the interaction between mass care and health and agriculture and the environment are put together and everybody is discharging his duty as the plan says. So, in incident management, we serve more of an advisory role.

Chairman LIEBERMAN. I know you pointed to some of the progress made, and I am pleased to hear it, obviously. This is so big a threat which is just to say that if it hits us, it is going to be such a challenge to respond to it in a way that limits the impact

on people's health or life. Tell me the two things that you think Congress could do which would best strengthen our national capacity to prevent and respond to a bioterrorist attack.

Dr. RUNGE. In terms of immediacy, and I probably will respond to that question by saying that there are many important things to do, but the most immediate thing, first of all, is paying close attention to countermeasure development for the threats that we know exist and that we have provided a stratification of threats.

Chairman LIEBERMAN. Which we don't really have adequately yet, do we, the countermeasures?

Dr. RUNGE. No, sir, we do not. Now, the Congress and Senator Burr and the PAPPA Act in December 2006 authorized the new BARDA, which is the advanced development part of HHS, ASPR; they are very busy over there, but the problem is that we still depend on small pharmaceutical firms, small technology firms to answer the call. There is insufficient incentive to large organizations, those that can bring the real power of their enterprise to bear. There is insufficient incentive to bring them to the dance to allow the full force of American enterprise to develop these sorts of countermeasures for us, whether they be vaccines or treatment for acute consequences.

Chairman LIEBERMAN. Yes. I totally agree with you on that, and it is an annoying problem. The failure to have adequate countermeasures is not the fault of your office or DHS. We just don't have them. They haven't been created or invented yet. Every time we try to create incentives, as some of us, Senator Burr and I and others have tried to do, to bring the big pharmaceutical companies into this, to create an incentive that the market does not normally create, we get pushed back because they say we are giving something away to big pharmaceutical companies. But we need big pharmaceutical companies to get on the field here. Otherwise, if this ever happens, we are just not going to have the countermeasures, the drugs to treat and inhibit the spread of that kind of disease.

I have gone over my time. I thank you for your work——

Dr. RUNGE. Could I just add one more thing, sir?

Chairman LIEBERMAN. Please.

Dr. RUNGE. The second thing is that hospital systems and other private sector entities—whether they be (private sector) ambulances, which are 50 percent of our ambulance runs—until they are incentivized to invest in preparedness rather than just trying to stave off the horrible problems of 130 percent of the census that they have right now every single day, if we don't incentivize them to invest in these low-probability events, we are never going to reach a position where we are truly prepared for disasters.

Chairman LIEBERMAN. Well, I appreciate that answer, and I would like to work with you on how to flesh that out.

Dr. RUNGE. Thank you.

Chairman LIEBERMAN. Senator Collins.

Senator COLLINS. Thank you. Dr. Runge, one of the tragedies that we observed in the response to Hurricane Katrina was how many homebound elderly and disabled citizens who simply could not evacuate themselves died or suffered great inconvenience and injury during the aftermath of the storm. I met recently with representatives of Home Health Agencies from around the Country

who pointed out that they can be a tremendous resource to FEMA and State and local emergency managers in helping to identify homebound elderly and disabled citizens. They know where they are in every community. And yet they felt that they are not fully involved in the planning for evacuation or emergency response.

You and I talked about this to some extent in my office. What will you do to more fully take advantage of the expertise and knowledge of home health agencies that might be invaluable in the event of a catastrophe?

Dr. RUNGE. Senator Collins, you actually piqued my interest when we talked about this, and I think I related to you that in my experience in Charlotte, S.C., I found that there was an army of people out there who were able to identify injury risks to elderly people who were at risk for alcohol abuse and so forth, and we actually implemented programs to get the Public Health System involved, not the health providers so much as the Meals on Wheels people and the people who just do in-home visitation and care.

I really do want to pursue this. I believe that is exactly the right thing to do in terms of identifying who it is that has a special need. We will be working with FEMA very closely through the regions. I don't have a plan for it right now, but I will be working with you and your staff on that.

Senator COLLINS. Admiral Johnson, I want to talk to you about a recent GAO report about the incredible amount of waste in the maintenance and deactivation contracts for the trailers and other manufactured housing that is being used for the Hurricane Katrina victims. As you know, the GAO estimated that for the period between June 2006 and January of this year alone, FEMA wasted more than $30 million in these contracts by using bidders who were not the most competitive, who did not offer the best price, and also by paying for work that was never completed. The report also found examples where there was a large payment to the prime contractor, but the individual who actually did the work received very little, suggesting that there were economies that could have been realized.

Now, FEMA put out an official press statement responding to the report, and it did not really dispute GAO's calculations. Instead, it blamed poor contracting decisions on the urgency of the crisis created by Hurricane Katrina. The problem with that explanation is GAO is looking at a 6-month period that is literally years after Hurricane Katrina struck.

This concerns me because although I see great progress by FEMA in awarding far fewer sole source non-competitive contracts, there still does not seem to be effective management of those contracts that are in force right now. What are you doing to improve the management of the contracts now in force?

Mr. JOHNSON. Moving away specifically from that audit to look at the general question, I think part of that I would thank the Congress for, and there are really three elements of this system. First of all, there needs to be a system, and so we have hired new people, such as our Director of Procurement, and have actually created a better structure to evaluate contracts. We actually have a contract assistance team now that takes a look at the contract and how it

hands off to those who implement the contract, and those two work together now where they did not before.

The second area is that we needed more contracting officers. In Hurricane Katrina, FEMA had 36 contracting officers. We now have 118 contracting officers. So you need to have more people who understand that business, and right now, everyone in government wants to hire those same people. It is a skill set that we all need.

And then the third is to use our contracting representatives (COTR). We now have a much more structured program that requires periodic education and training to sustain their qualification actually to enforce and oversee contracts. In the Gulf Coast specifically, we created a Program Management Office that now has a quality assurance surveillance program to ensure that those who are contracted for services provide that service. And that also includes a customer satisfaction survey from travel trailer occupants who sometimes are the most prone to give us information that we need to ensure that the contractor is meeting their responsibilities.

So we take that audit very seriously. We didn't challenge its findings. We know we made mistakes in Hurricane Katrina. We didn't challenge its recommendations because they were on target, and we are focused on how we can actually implement those recommendations.

Senator COLLINS. Thank you.

Chairman LIEBERMAN. Thanks very much, Senator Collins. Senator Tester.

Senator TESTER. Yes, thank you, Mr. Chairman.

Mr. Johnson, in your opening statement, you spoke about partnerships. Very briefly, could you explain to me how you initiate and develop partnerships and who they are with?

Mr. JOHNSON. We have partnerships across the board, at the Federal, State, and local levels, with the private sector, with nongovernmental organizations, and again, I point back to PKEMRA that now requires FEMA for the first time to have a National Advisory Council. That advisory council has 36 members with very structured recommendations about what backgrounds they bring to FEMA. That National Advisory Council met for the first time in October and had a conference call 2 weeks ago. We will meet again in February. It requires every region to have their own advisory council, and those have been established and for the most part have already had their first meeting. And so we have those advisory councils.

We meet with what is called the Homeland Security Consortium, and the consortium represents State and local interests, private sector interests, all involved in homeland security, and we just attended their primary meeting in New Orleans 2 weeks ago. As I mentioned, we started a Loaned Executive Program. UPS is our first corporation. And we have established a Private Sector Office in FEMA. So we are very focused on how we can build those partnerships.

Senator TESTER. And I would assume most of those partnerships are for the purpose of helping you do your job more effectively, which would include taking advice from them on issues of concern when it comes to an emergency.

Mr. JOHNSON. Exactly.

Senator TESTER. OK. On August 31, 2006, FEMA began refurbishing a former Army base in Anniston, Alabama, to house approximately 1,000 Hurricane Katrina evacuees, spending almost $8 million to make it inhabitable. It opened on September 15. According to the GAO, FEMA went ahead with the project despite warnings from FEMA officials in Alabama that the rooms were not needed. It turns out that they weren't needed. It stayed open for about 2 months and was later closed. What is your response to that? If you are to develop partnerships and get information from local folks and even the local folks in your own agency you are not listening to, what is the purpose of that? I mean, why?

Mr. JOHNSON. I am not familiar enough with that facility to answer a question specific to that, and so I would be pleased if, with your permission, I could get back to you.

Senator TESTER. That would be absolutely good.

On another issue, the White House appears interested in terminating the Emergency Performance Management Grant Program. It allows our communities to develop emergency management plans to respond to disaster. What is your view about this program?

Mr. JOHNSON. Well, sir, as you know, that is part of a program built into the fiscal year 2009 budget, and what was released, unfortunately to the media, was the beginnings of an iterative discussion between elements of the Administration on how should we approach grants.

Senator TESTER. So it is still in, is what you are saying, and you support the program?

Mr. JOHNSON. That is correct.

Senator TESTER. OK. Thank you very much.

Dr. Runge, very quickly, I want to thank you very much for coming to visit me 2 to 3 weeks ago. At this point in time, I want to clarify, your agency is to respond, not to preempt, is that correct? Is that a fair classification?

Dr. RUNGE. Not really. We have a comprehensive approach toward WMD and biodefense and to planning——

Senator TESTER. OK.

Dr. RUNGE [continuing]. For Federal planning, incident management coordination, grants coordination, and so forth.

Senator TESTER. Perfect. You talked about the private sector's involvement and you talked about the fact that they need to be incentivized to be involved. Your best guess right now, what is the private sector's involvement at this point in time? Is it nonexistent or 50 percent?

Dr. RUNGE. Here is the problem, Senator Tester, with respect to those that will be providing care in a disaster: They will do the best job that they can possibly do, and it happens time and time again. If there is a plane crash or if there is a tornado or whatever, these people, whether they are public or private sector health care systems, rally. They do the very best they can.

Senator TESTER. Right.

Dr. RUNGE. The problem is that the scenarios that we are using, the canonical scenarios that we are gaming out, will undoubtedly result in a complete overwhelming of the health care system. We have not yet offered them guidance in terms of, if they reach cer-

tain levels of preparedness, what are we as a Federal Government prepared to do to protect them from liability issues, for instance.

Senator TESTER. Got it.

Dr. RUNGE. So there are incentives that we can build into our planning, I think, that will help with this.

Senator TESTER. That would be good. You may already have these and if you do, that is great. I would love to have your recommendation on incentives that we could put forth to the private sector. I think it would be worth my look at it.

When we visited one-on-one in my office, we talked a little bit about agriculture and potential terrorism that could revolve around that. Do you plan to or have you decided to hold exercises with State and local governments on this kind of potential agricultural terrorism?

Dr. RUNGE. Yes, sir. My second planning priority is foot and mouth disease. USDA has a playbook for foot and mouth disease for agricultural units, for State agriculture and for local agriculture and for USDA, but we don't have an end-to-end plan.

Senator TESTER. OK.

Dr. RUNGE. There is no question that this would be a devastating thing for Montana.

Senator TESTER. And the country.

Dr. RUNGE. We have to get an end-to-end plan in place and drill it and test it, exercise it, and figure out how to fund it.

Senator TESTER. When do you anticipate that happening?

Dr. RUNGE. We have committed to the Secretary to do it by the end of this fiscal year.

Senator TESTER. OK, good. I look forward to that occurring, too.

In closing, I want to thank both of you for your public service over the many years that you folks have worked in the private sector and the public sector. I want to thank you for putting yourself in front of this Committee and putting yourself in front of the people for the job that you hope to be confirmed for. So thank you very much.

Dr. RUNGE. Thank you, sir.

Chairman LIEBERMAN. Thanks, Senator Tester. I couldn't agree with you more. I thank you both for your testimony today; some tough questions, but you responded to them.

I particularly want to thank you, Admiral Johnson, for your response to the question that Senator Tester just asked you about the Emergency Management Grant Programs. Today, Senator Collins and I and Chairman Bennie Thompson and Ranking Member Peter King from the House have sent a letter out. The rumor that has been in the press about the Administration proposing a fiscal year 2009 budget cutting out these grant programs, which we have just, Congress and the President signed the Act, "permanentized," if I can make up that word, in the second phase of the 9/11 legislation is very troubling to us, so I appreciate your clarification and I like your terminology. This is at the stage of it being an iterative process, not a decisive or conclusive process. So we will make sure you get a copy of that letter.

I thank you both. Without objection, the record of this hearing is going to be held open until 12 noon tomorrow for the submission of any written questions or statements for the record. We have

done that so quickly because it is my intention and Senator Collins' intention to move these nominations as quickly as we can through the Committee. Now, I take note obviously of what Senator Landrieu said, and I hope that you can both meet with her and hopefully we can go ahead because I would, if I can use the word again, I would like to permanentize both of you. I was going to say institutionalize both of you, but——

Dr. RUNGE. Please don't. [Laughter.]

Chairman LIEBERMAN. Probably your families think you should already be institutionalized for going ahead with these jobs. But in any case, I hope those conversations go well. But I thank you for your public service.

Senator Collins, do you want to add anything?

Senator COLLINS. No. Thank you.

Chairman LIEBERMAN. Thank you. The hearing is adjourned.

[Whereupon, at 11:43 a.m., the Committee was adjourned.]

A P P E N D I X

Statement of

Harvey E. Johnson Jr.

Deputy Administrator

Federal Emergency Management Agency

Department of Homeland Security

Before

Senate Committee on Homeland Security and

Governmental Affairs

Wednesday, December 12, 2007

10 a.m.

Washington, DC

Good Morning Chairman Lieberman, Senator Collins and distinguished Members of the committee.

I am honored to come before you today as the President's nominee to serve as the Deputy Administrator of the Federal Emergency Management Agency (FEMA), as reorganized under the direction of the Post Katrina Emergency Management Reform Act. It has been my distinct privilege to serve over the past 20 months in this capacity alongside FEMA Administrator David Paulison, and I welcome the opportunity to continue my service with him, to FEMA and to the American people we serve. I appreciate the confidence placed in me by President Bush and by Secretary Chertoff.

I would like to thank my family for their constant support as I have served as Acting Deputy Administrator, particularly the support of my wife Janet, who is with me here this morning. Janet is joined by my daughter Jennifer, who is a young professional residing here in Washington DC. My son Scott would like to have been present, but is a working professional in New York City. The demands upon all leaders in FEMA can sometimes be consuming and unpredictable. But my family recognizes that I have been given a tremendous opportunity to serve our Nation and to make a difference.

My family also understands that service has both its challenges and its rewards, as I have spent close to 40 years in public service. I learned almost all that I know of leading individuals and organizations while serving 35 years in the United States Coast Guard. That is where I began as an operator aboard a cutter, transitioned into the cockpit of a

helicopter, and exercised command from an operational command center. That is where I learned that government really can serve its citizens when they are in need, and can do so efficiently, effectively and with passion and compassion. And, that such service can be rewarding beyond measure.

My journey to this hearing began in 1971 as I entered the U.S. Coast Guard Academy in New London, Connecticut, and later was commissioned an Ensign in 1975. I gained my sea legs aboard the Coast Guard Cutter Steadfast where I learned to appreciate the art and science of seamanship and the value of leadership and teamwork toward common objectives. I earned my Coast Guard aviator wings 1977, and piloted all of the Coast Guard's helicopters over the next 22 years in the conduct of law enforcement missions and search and rescue. I learned to be exacting in mental and aeronautical preparation as errors in judgment can be costly to men and women in my aircraft as well as those whom we embarked in progress of a search and rescue mission.

As I continued my service, I gained invaluable experience in managing and contributing to an organization dedicated to saving lives, protecting the environment and enforcing the law. I learned to embrace the Coast Guard's core values of Honor, Respect and Devotion to Duty and to make them my own. I gained experience in finance, people management, strategic planning, inter-agency operations and consensus building, all skills that benefit me now in meeting my responsibilities in FEMA. The Coast Guard afforded me the opportunity to pursue formal education, as I earned a Masters of Science degree at the Naval Postgraduate School, and a second Masters degree at the Sloan School of Management at the Massachusetts Institute of Technology.

Building on these experiences, I was honored to be selected for command of two Air Stations and an Activities command. I was particularly honored to have been selected as a Flag officer where I applied my experience and contributed as a member of the Coast Guard senior leadership team in shaping mission performance to measurably affect outcomes. I was selected by the Commandant to lead the Coast Guard's integration into the Department of Homeland Security, and now work to strengthen the Department from a different perspective. At Flag level, I commanded the Coast Guard's Seventh District in Miami, Florida – it most intensive operationally oriented area of operation – and as a Vice Admiral, commanding the Coast Guard's Pacific Area, its largest geographic expanse which included all Coast Guard missions from the Rocky Mountains to Far East - and did both successfully, with benefit of thousands of motivated and dedicated Coast Guard men and women.

I describe my extensive operational background and breadth of leadership experience humbly and without undue pride, not for self promotion, but to submit to you that I am qualified and prepared to accept the responsibilities for which I have been nominated by the President and for which I ask for your confirmation.

Working with Administrator Paulison, we have set a Vision for New FEMA that charts a course to becoming the Nation's preeminent emergency management and preparedness agency. We established an ethos of leaning forward to provide more effective assistance to disaster victims and communities. And it is our objective to develop operational core competencies, strengthen a dedicated workforce, and foster a business approach to business. As we, and every member of the FEMA team, work toward these objectives,

our intent is to better prepare the Nation against the risk of an all-hazards disaster. And when that disaster does occur, to marshal a more effective national response, and work more purposefully to speed the recovery of disaster victims and communities.

By establishing the moniker of *New FEMA*, we recognize that judgment on our progress will be determined by our actions not our words. So as we have turned our words into actions this past year, our opportunity for success has been strengthened by three supporting elements. First, a dedicated workforce comprised of proud and resourceful professionals men and women. Second, a supportive Congress who has provided the tools we need in the form of legislation and constructive oversight. Third, an operational focused President and Secretary who have requested the resources that we need and demonstrated confidence in our leadership and decision making.

Though difficult and challenging to walk beyond the shadow of Katrina, that vision is steadily being replaced by a more confident and competent New FEMA. It was New FEMA that responded to tornadoes in Florida, Georgia and Alabama; to the Nor'easter that ran across New England last Fall, the floods and ice storms that have (and are now) plaguing the mid-West, and most recently, the wildfires in California. Now to be sure our success was a enhanced by engaged partnerships across our Federal, State and local jurisdictions, the non-governmental organizations and the private sector, but the leadership was New FEMA.

Mr. Chairman, Senator Collins and distinguished Members of the committee, I thank you again for considering my nomination. If confirmed, I pledge to continue working closely with you to achieve the objective that we share, and that is to ensure the safety and security of the American people. I thank you and look forward to responding to your questions.

REDACTED

BIOGRAPHICAL AND FINANCIAL INFORMATION REQUESTED OF NOMINEES

A. BIOGRAPHICAL INFORMATION

1. **Name:** (Include any former names used.)
   Harvey Elwood Johnson, Jr.

2. **Position to which nominated:**
   Deputy Administrator/Chief Operating Officer – Federal Emergency Management Agency

3. **Date of nomination:**

4. **Address:** (List current place of residence and office addresses.)
   Residence:
   Office: 500 C Street, SW – Washington, DC 20492

5. **Date and place of birth:**
   24 October 1953
   Tampa, FL

6. **Marital status:** (Include maiden name of wife or husband's name.)
   Married: Janet Louise Cronin (Maiden Name)

7. **Names and ages of children:**
   Jennifer Diane Brandely - age 29
   Scott David Johnson - age 24

8. **Education:** List secondary and higher education institutions, dates attended, degree received and date degree granted.
   HB Plant High School (September 1967 – June 1971)
   Diploma; June 1971

   US Coast Guard Academy (June 1971 – June 1975)
   BS Economics/Management; June 1975

   Naval Postgraduate School (June 1982 – May 1983)
   MS Management; May 1983

   Massachusetts Institute of Technology (July 1992 – June 1993)
   MS; June 1993

9. **Employment record:** List all jobs held since college and any relevant or significant jobs held prior to that time, including the title or description of job,name of employer, location of work, and dates of employment. (Please use separate attachment, if necessary.)

June 1992 – June 1993	Sloan Fellows Program MIT – Cambridge, MA
June 1993 – June 1994	Coast Guard Air Station – Brooklyn, NY Commanding Officer US Coast Guard
June 1994 – June 1995	Commandant's Streamlining Study Senior Team Leader US Coast Guard
June 1995 – June 1997	Commandant, G-CPA Deputy Chief, Programs Division US Coast Guard
June 1997 – July 1999	Commander, Coast Guard Activities San Diego Commanding Officer, Coast Guard Air Station San Diego US Coast Guard
July 1999 – April 2000	Chief of Naval Operations Strategic Study Group CNO Fellow US Coast Guard
April 2000 – June 2001	Commandant (G-C-10) Executive Assistant US Coast Guard
June 2001 – June 2002	Commandant (G-OC) Director Operations Capability US Coast Guard
June 2002 – June 2003	Commandant (G-OP) Director Operations Planning US Coast Guard
June 2003 – June 2004	Commander, Seventh Coast Guard District District Commander US Coast Guard
June 2004 – May 2006	Commander, Coast Guard Pacific Area Area Commander US Coast Guard
May 2006 – Present	Federal Emergency Management Agency Deputy Administrator/Chief Operations Officer

Note: Entered the United States Coast Guard Academy in June 1971 and continued Coast Guard active duty service until May 2006. This listing of Coast Guard duty stations can be expanded to address the full period if desired.

10. **Government experience:** List any advisory, consultative, honorary or other part-time service or positions with federal, State, or local governments, other than those listed above.

None

11. **Business relationships:** List all positions currently or formerly held as an officer, director, trustee, partner, proprietor, agent, representative, or consultant of any corporation, company, firm, partnership, or other business enterprise, educational or other institution.

None

12. **Memberships:** List all memberships, affiliations, or and offices currently or formerly held in professional, business, fraternal, scholarly, civic, public, charitable or other organizations.

Coast Guard Academy Alumni Association
Deacon, First Baptist of Herndon

13. **Political affiliations and activities:**

(a) List all offices with a political party which you have held or any public office for which you have been a candidate.
None

(b) List all memberships and offices held in and services rendered to any political party or election committee during the last 10 years.
None

(c) Itemize all political contributions to any individual, campaign organization, political party, political action committee, or similar entity of $50 or more during the past 5 years.
None

14. **Honors and awards:** List all scholarships, fellowships, honorary degrees, honorary society memberships, military medals and any other special recognitions for outstanding service or achievements.

Coast Guard Distinguished Service Medal; Legion of Merit (4), Meritorious Service Medal (3), Coast Guard Commendation Medal (3), Coast Guard Achievement Medal, Coast Guard Commandant's Letter of Commendation Ribbon, Coast Guard Unit Commendation (5), Coast Guard Meritorious Unit Commendation (3), Coast Guard Meritorious Team Commendation (3), Coast Guard Bicentennial Unit Commendation, National Defense Service Medal, Humanitarian Service Medal, Coast Guard Special

Operations Service Ribbon, Coast Guard Sea Service Ribbon, Coast Guard Sharpshooter Rifle Ribbon, Coast Guard Sharpshooter Pistol Ribbon.

15. **Published writings:** Provide the Committee with two copies of any books, articles, reports, or other published materials which you have written.

None

16. **Speeches:**

(a) Provide the Committee with two copies of any formal speeches you have delivered during the last 5 years which you have copies of and are on topics relevant to the position for which you have been nominated. Provide copies of any testimony to Congress, or to any other legislative or administrative body.

(b) Provide a list of all speeches and testimony you have delivered in the past 10 years, except for those the text of which you are providing to the Committee. Please provide a short description of the speech or testimony, its date of delivery, and the audience to whom you delivered it.

17. **Selection:**

(a) Do you know why you were chosen for this nomination by the President?

The Secretary of the Department of Homeland Security appointed me in May of 2006, to serve as the Deputy Director and Chief Operating Officer of FEMA. At the outset, the Secretary described the challenges of leading FEMA in the post-Katrina environment and plainly established his high expectations. During the course of the last 16 months, I have addressed the challenges forthrightly, established a course of progress and accountability to achieve Administrator Paulison's vision for New FEMA, and met or exceeded the Secretary's expectations. I believe it was on this basis of performance, and with expectations to continued leadership, that the President nominated me for this position.

(b) What do you believe in your background or employment experience affirmatively qualifies you for this particular appointment?

Before assuming the responsibilities of my current position, I completed a highly successful and accomplished 35 years of career service in the United States Coast Guard. During that period of service, I developed and honed expertise in leadership, management of scarce resources, operational decision making, and strategic planning. And, I did so building a reputation as a pragmatic, innovative change agent who is well grounded personally and professionally, high and focused energy, demanding yet fair, and able to articulate a vision and lead to vision accomplishment. These are my skill sets, and exactly the skill sets one needs to lead the organizational transformation of FEMA.

B. EMPLOYMENT RELATIONSHIPS

1. Will you sever all connections with your present employers, business firms, business associations or business organizations if you are confirmed by the Senate?

   Yes, not an issue.

2. Do you have any plans, commitments or agreements to pursue outside employment, with or without compensation, during your service with the government? If so, explain.

   No.

3. Do you have any plans, commitments or agreements after completing government service to resume employment, affiliation or practice with your previous employer, business firm, association or organization, or to start employment with any other entity?

   No.

4. Has anybody made a commitment to employ your services in any capacity after you leave government service?

   No.

5. If confirmed, do you expect to serve out your full term or until the next Presidential election, whichever is applicable?

   Yes.

6. Have you ever been asked by an employer to leave a job or otherwise left a job on a non-voluntary basis? If so, please explain.

   No.

C. POTENTIAL CONFLICTS OF INTEREST

1. Describe any business relationship, dealing or financial transaction which you have had during the last 10 years, whether for yourself, on behalf of a client, or acting as an agent, that could in any way constitute or result in a possible conflict of interest in the position to which you have been nominated.

   None.

2. Describe any activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat or modification of any legislation or affecting the administration or execution of law or public policy, other than while in a federal government capacity.

   None.

3. Do you agree to have written opinions provided to the Committee by the designated agency ethics officer of the agency to which you are nominated and by the Office of Government Ethics concerning potential conflicts of interest or any legal impediments to your serving in this position?

   Yes

D. LEGAL MATTERS

1. Have you ever been disciplined or cited for a breach of ethics for unprofessional conduct by, or been the subject of a complaint to any court, administrative agency, professional association, disciplinary committee, or other professional group? If so, provide details.

   No.

2. Have you ever been investigated, arrested, charged or convicted (including pleas of guilty or nolo contendere) by any federal, State, or other law enforcement authority for violation of any federal, State, county or municipal law, other than a minor traffic offense? If so, provide details.

   No.

3. Have you or any business of which you are or were an officer, director or owner ever been involved as a party in interest in any administrative agency proceeding or civil litigation? If so, provide details.

   None in a personal capacity.

   Professional Capacity:
   Watson v. FEMA, Civil Action No. H-06-1709 (U.S.D.C. So. Dist. TX).

4. For responses to question 3, please identify and provide details for any proceedings or civil litigation that involve actions taken or omitted by you, or alleged to have been taken or omitted by you, while serving in your official capacity.

   N/A

5. Please advise the Committee of any additional information, favorable or unfavorable, which you feel should be considered in connection with your nomination.

   None

E. FINANCIAL DATA

All information requested under this heading must be provided for yourself, your spouse, and your dependents. (This information will not be published in the record of the hearing on your nomination, but it will be retained in the Committee's files and will be available for public inspection).

Harvey E. Johnson being duly sworn, hereby states that he/she has read and signed the foregoing Statement on Biographical and Financial Information and that the information provided therein is, to the best of his/her knowledge, current, accurate, and complete.

Harvey E Johnson

Subscribed and sworn before me this 26th day of November, 2007

Loretta Schaffer
Notary Public

U.S. Senate Committee on Homeland Security and Governmental Affairs
Pre-hearing Questionnaire
For the Nomination of Harvey E. Johnson to be
Deputy Administrator, Federal Emergency Management Agency at the Department of Homeland Security

I. Nomination Process and Conflicts of Interest

1. **Why do you believe the President nominated you to serve as Deputy Administrator for the Federal Emergency Management Agency (FEMA)?**

The Secretary of the Department of Homeland Security appointed me in May of 2006, to serve as the Deputy Administrator for FEMA. At the outset, the Secretary described the challenges of leading FEMA in the post-Katrina environment and plainly established his high expectations. During the course of the last sixteen months, I have addressed the challenges forthrightly, established a course of progress and accountability to achieve Administrator Paulison's "Vision for New FEMA," and met or exceeded the Secretary's expectations. I believe it was on the basis of this performance, and with expectations to continue leadership, that the President nominated me for this position.

2. **Were any conditions, express or implied, attached to your nomination? If so, please explain.**

No.

3. **What specific background and experience affirmatively qualifies you to be Deputy Administrator for FEMA?**

Before assuming the responsibilities of my current position, I completed a highly successful and accomplished thirty-five years of career service in the United States Coast Guard. During that period of service, I developed and honed expertise in leadership, management of scarce resources, operational decision making, and strategic planning. And, I did so building a reputation as a pragmatic, innovative agent of change. I am well grounded personally and professionally, demanding yet fair. I am able to articulate a Vision and lead to Vision accomplishment. These are my skill sets, and exactly the skill sets one needs to lead the organizational transformation of FEMA.

4. **Have you made any commitments with respect to the policies and principles you will attempt to implement as Deputy Administrator for FEMA? If so, what are they, and to whom were the commitments made?**

If confirmed, I will remain focused on implementing the policies and principles that comprise Administrator Paulison's Vision for New FEMA. This Vision has guided the significant improvements that FEMA has made in disaster operations, disaster assistance, logistics and all of our core business processes. Pursuit of the Vision is a multi-year effort of continuous improvement. Our initial efforts are focused on building a sustainable organizational structure in

Headquarters and the Regions, selecting and supporting quality leaders, instituting standard business processes supported by measures and metrics, and strengthening partnerships across all levels of government, with non-governmental organizations, the private sector and individuals whom we serve. Working with Administrator Paulison, I intend to continue to lead and direct progress to attain the Vision for New FEMA.

5. **If confirmed, are there any issues from which you may have to recuse or disqualify yourself because of a conflict of interest or the appearance of a conflict of interest? If so, please explain what procedures and/or criteria that you will use to carry out such a recusal or disqualification.**

No.

6. **Have you ever been asked by an employer to leave a job or otherwise left a job on a non-voluntary basis? If so, please explain.**

No.

II. Policy Questions

7. **In your view, would it be beneficial for FEMA to remain within or be removed from DHS? Please explain.**

I strongly believe that FEMA should remain an integral part of the Department of Homeland Security (DHS).

The intent of the Homeland Security Act was to create a unified DHS that operates as an all hazards, integrated organization. FEMA, like our sister DHS agencies, is a critical team player in working with State and local entities and the private sector to prepare for, respond to, mitigate, and recover from disasters.

With over 180,000 employees, DHS is well situated to support FEMA's personnel needs during a disaster, providing vast and immediately available surge capacity (FEMA has approximately 2,500 full time and as many as 5,000 disaster staff). During Hurricane Katrina, thousands of DHS employees supported disaster response and recovery operations both in the field and at headquarters. Also, the Department has undergone three reorganizations in the past four years and should not go through another one at this time.

Lastly, the Homeland Security Act together with Homeland Security Presidential Directives 5, 7, and 8 have created the statutory and policy structure for the Secretary of Homeland Security to serve as the national incident manager. Separating FEMA would disrupt the unity of command and we would lose the synergies created between FEMA and other operating components of the Department. DHS must operate as an all-hazards integrated organization.

I respectfully submit that FEMA should continue to reform and improve as part of the DHS family.

8. **What do you see as the limitations of FEMA's ability to accomplish its mission(s) were FEMA to again become an independent agency?**

As discussed in the previous answer, leaving DHS would deprive FEMA of direct access to 180,000 DHS personnel, and a wealth of DHS capabilities. It would also deprive our sister DHS agencies of FEMA's capabilities. The previous independent agency model for FEMA is not suited for 21st century disasters, which include acts of terrorism designed to cause maximum harm to persons and infrastructure. While each agency in DHS has unique responsibilities, our most important missions are shared as a department and must be approached as such.

Having FEMA within DHS enables the Department to take an "all-hazards" approach to disaster management during both natural and man-made events. We can integrate our efforts with DHS' other operational components, including the U.S. Coast Guard, thereby ensuring a more effective response and recovery. Moving FEMA out of DHS would deprive FEMA of the direct ties it has with other DHS agencies and DHS leadership. Also, FEMA's inclusion in DHS enables the integration of FEMA in DHS' overall preparedness functions. Removing FEMA would sever this link.

Lastly, separating FEMA from DHS would result in an independent but weak agency that would exist in tension with DHS, creating two separate agencies to deal with disasters. FEMA and DHS leadership would waste valuable time re-creating relationships as different disasters arose, impeding both departments' ability to carry out their missions. All DHS agencies are improving their interoperability; not being a part of this expanding capability would strip FEMA of valuable abilities, and likely result in FEMA's failure during a disaster of any sizeable magnitude.

9. **The Committee is concerned that some deadlines in the Post-Katrina Emergency Management Reform Act of 2006 (P.L. 109-295) (Post-Katrina Act) have been missed and seeks an update on the status of the implementation of various sections of the Post-Katrina Act. Please complete the chart below.**

FEMA, including the elements that merged on March 31, 2007, was tasked with over 250 distinct requirements for actions and deliverables by the Post Katrina Emergency Management Reform Act of 2006 (PKEMRA). Many of these items are complete, and substantial progress has been made on those that remain. Our policy has been to strive for quality and substance vice a rushed response, and we believe this has been reflected in the myriad of briefs, reports, and actions completed to date. We have frequently engaged with the Department and the Congressional committees to advise on the status of our remaining deliverables, and are working diligently to complete the remaining slate of action items.

Section	Statutory Requirement	Federal Emergency Management Agency imposed Deadline (if any)	Current Status of fulfilling requirements of listed statutory requirement and explanation of reason for any delay	For any missed statutory deadline, please proved the projected date by which FEMA intends to meet the statutory requirements
621 (adding 5 USC 10102(a))	April 4, 2007	October 31, 2007	FEMA must submit a Strategic Human Capital Plan. Original due date of April 4, 2007 was four days after FEMA began completely reorganizing, merging with National Preparedness, Grants and Training, the National Capitol Region Staff, etc. FEMA is creating a comprehensive strategy to address our new work force, addressing the needs of all of our components, new and legacy.	FEMA anticipates submitting the Strategic Human Capitol Plan to Congress in late December 2007.
621 (adding 5 USC 10106)	January 4, 2007 and every three months thereafter	January 4, 2007	This is a recurring quarterly requirement. FEMA has submitted Human Capital Vacancy Reports for FY07 Q1 and Q2. A report for both FY07 Q3 and Q4 will be submitted shortly. FEMA is transitioning between HR tracking software, delaying submission of the report. FEMA is also incorporating additional data requested by Congress after Q1 and Q2 reports were submitted.	FEMA anticipates submitting the Q3 and Q4 report to Congress in November 2007. FEMA has also requested a revised due date after each quarter, allowing FEMA time to prepare and review this Congressional deliverable (the current due date is four days after the end of each quarter)
624	April 4, 2007	August 15, 2007	FEMA is developing the Surge Capacity Workforce Plan. The Administrator's office is working to expedite its completion.	FEMA anticipates completing this plan by late January 2008.

640	July 4, 2007	June 30, 2007	This report on measures FEMA has taken to improve its IT systems is in the final stages of review, and will be submitted to Congress shortly.	FEMA anticipates delivering this report to Congress in November 2007.
652	October 4, 2008	September 30, 2007	FEMA is creating/modifying several preparedness and disaster resource systems to gather data, in part, for the Catastrophic Resource Report. Accurately collecting and analyzing the needed data is complicated.	FEMA anticipates initial drafts of this report being prepared in late Spring 2008.
653	4-Oct-08		As of August 2007, 183 pre-scripted mission assignments existed. FEMA briefed the House and Senate Appropriations Committees on this progress on October 30, 2007.	This requirement has been met.
682	July 4, 2007	June 1, 2007	Completing the National Response Framework (NRF) and the National Disaster Housing Strategy (NDHS) is a prerequisite to completing the National Disaster Strategy. The NRF and NDHS should both be complete in December 2007.	The National Disaster Strategy should be complete in March 2008.
683	July 4, 2007	Summer 2007	The National Disaster Housing Strategy has undergone revisions to address formaldehyde issues raised in trailers over the last year.	The National Disaster Housing Strategy should be complete by December 2007.
689(a)	January 4, 2007	Winter 2007/2008	Developing standards for individuals with disabilities.	At present, FEMA believes that changes in this area will require legislative action. .
689c(f)	July 4,2007		The report on the	FEMA

			National Emergency Family Registry and Locator System is in the final stages of review and will be submitted to Congress shortly.	anticipates delivering this report to Congress in November 2007.
691(a)	April 4, 2007	June 15, 2007	The report on advanced contracting and strategies is in the final stages of review, and will be submitted to Congress shortly.	FEMA anticipates delivering this report to Congress in November 2007.
691(b)	October 4, 2007	September 30, 2007	The report on advanced contracting and strategies is in the final stages of review and will be submitted to Congress shortly.	FEMA anticipates delivering this report to Congress in November 2007.
691(d)	March 31, 2007	June 15, 2007	This is a recurring quarterly requirement. FEMA has submitted reports for disaster contracting in FY07 Q1 and Q2. A report for both FY07 Q3 and Q4 will be submitted shortly. Between July 2007 and present, FEMA procurement was focused on end of year contracting actions and closeouts.	FEMA anticipates delivering this report to Congress in November 2007. FEMA has also requested a revised due date after each quarter, allowing FEMA time to prepare and review this Congressional deliverable (the current due date is the last day of each quarter)

10. **Please describe briefly the current status of implementation of the following sections of the Post-Katrina Act:**

a. Section 692

Section 692 requires the Secretary of Homeland Security to promulgate regulations that ensure that contracting agencies limit the excessive use by contractors of subcontractors or tiers of subcontractors to perform the principal work of the contract. Specifically, the legislation precludes a contractor from using subcontracts for more than 65 percent of the cost of the contract or the cost of any individual task or delivery order (not including overhead and profit), unless the Secretary determines that such a requirement is not feasible or practicable.

Final implementation of official standard operating procedures in reference to the legislation is contingent upon the Federal Acquisition Regulation (FAR) Council approval and subsequent changes to the FAR which FEMA ultimately follows when conducting procurements. However, FEMA's contracting personnel have been informed of the law through informational postings on the Office of Acquisition Management's (OAM's) Virtual Acquisition Office as well as in training sessions. A notice will also be included in the next published version of the Homeland Security Acquisition Regulation (HSAR). The regulation is under development at the Department.

b. Section 695

Section 695 limits the length of time a disaster-related contract may remain active when it is awarded noncompetitively for urgent and compelling reasons. Unless special circumstances apply and proper justification and approval is received from the appropriate level official, contracts of this nature must be replaced by competitively-awarded contracts after 150 days.

FEMA's contracting personnel have been informed of the law through informational postings on the Office of Acquisition Management's Virtual Acquisition Office as well as in training sessions, and a notice in the Homeland Security Acquisition Manual (HSAM). However, final implementation of official standard operating procedures in reference to the legislation is contingent upon the approval of the Federal Acquisition Regulation Council and subsequent changes to the FAR which FEMA ultimately follows when conducting procurements. This regulation is under internal review.

The requirements which came about as a result of Hurricane Katrina required many contracts to be issued noncompetitively under unusual and compelling urgency. Since that time, FEMA has learned many lessons and has made considerable strides in the number of contract actions it awards competitively. In Fiscal Year 2006, FEMA awarded approximately 54 percent of its contract actions using competitive procedures, ranking last among all Department of Homeland Security components. However, due to various initiatives implemented by the Office of Acquisition Management, FEMA competitively awarded approximately 70 percent of its contract actions in Fiscal Year 2007, ranking second among all DHS contracting components.

In order to achieve this significant improvement, OAM implemented pre- position contracts. As a result many requirements were negotiated in advance of a disaster which ensures requirements are competed and the right products and services are deployed in a timely manner. OAM also established an Acquisition Program & Planning (APP) office which directly interfaces with the program offices ensuring acquisition strategies are in place to allow for competitive awards. The Acquisition Operations staff also increased in Fiscal Year 2007. During Hurricane Katrina, the operations staff had thirty-five contracting professionals; the staff is now comprised of 116 contracting professionals. The Agency has significantly increased its staffing levels since Hurricane Katrina in order to ensure that the agency has the proper resources to meet urgent contracting needs in a timely manner and award competitive contracts.

While FEMA's mission as a disaster response agency means that competitive procedures may not always meet the urgent mission requirements to procure goods and services, the Agency

supports the view that competition is the cornerstone of the Federal government's acquisition system. The benefits of competition are well established. It ensures a fair and reasonable price, improves contractor performance, and promotes accountability for results. FEMA will continue to strive to utilize competitive procedures whenever possible.

c. Section 696

Section 696 requires the Administrator ensure that -

(1) all programs within the Agency administering Federal disaster relief assistance develop and maintain proper internal management controls to prevent and detect fraud, waste, and abuse

FEMA has actively developed better controls to prevent waste, fraud and abuse in disaster assistance payments. These controls include system enhancements to better check the identities of disaster victims, new policies and procedures governing assistance to applicants who fail identity verification, system enhancements to prevent duplication of benefits, and stricter controls on contracted activities. The details of these improvements were outlined in FEMA's August 2007 Report to Congress titled: Instituting Revisions to Identity Validation Process. We are making progress in identifying and implementing corrective action plans which address these controls in the payment and financial reporting process, these corrections in internal controls both determining eligibility for payments and controls of the payment themselves. However, the impact of these corrections will need to be monitored and tested over time to ensure that the new controls are effective. As part of our compliance with OMB Circular A-123, FEMA will be updating its assessment of internal controls for all FEMA programs and testing high-risk programs.

Section 696 requires the Administrator ensure that –

(2) application databases used by the Agency to collect information on eligible recipients record disbursement

FEMA's databases meet this requirement.

Section 696 requires the Administrator ensure that -

(3) Such tracking is designed to highlight and identify ineligible applications

Ineligible applicants are identified in the National Emergency Management Information System (NEMIS). Eligibility status is displayed prominently on the Overview screen (the first screen that opens up). Additionally, we maintain all ineligibility decisions on the Housing Assistance tab of NEMIS, where caseworkers can easily identify ineligible applicants.

The identity verification (IDV) pass/fail notification is done while the registration is being completed when the applicant first calls or registers online. If the IDV results in a fail, the

caller agent attempts to correct the information (checks spelling of name, etc.) and if that does not correct the issue, they will complete the registration. The case will not be processed for any automatic payments and the applicant will be sent a letter advising them of the IDV fail status and how they can correct it. Online, the applicant cannot continue their application and are instead, referred to the 1-800 number to speak with a caller agent.

Section 696 requires the Administrator ensure that -

(4) The database used to collect information from applications for such assistance must be integrated with disbursement and payment records

At the current time, NEMIS shares data with the agency's financial system. While the systems are integrated at the big picture level, there remain problems with payments/actions on the fringes (NIFRA, recoupments). On the big picture level, NEMIS sends a record to IFMIS to be paid. When the record is disbursed, NEMIS looks into IFMIS to show the caseworker the status of that particular payment, such as when it was disbursed. For recoupments, we have a similar relationship, where we send a record to IFMIS stating that a particular payment or group of payments are being recouped though IFMIS does not communicate actions taken back to the NEMIS record. Additionally, if a problem with a payment is identified by IFMIS, payments rejected by IFMIS are integrated into the NEMIS workflow to create a record that a caseworker can pick up to resolve the problem.

d. Section 697

It is FEMA's intent to support the Section 697 requirement by modifying the Central Contractor Registration (CCR), the database in which every government contractor is required to register, as opposed to creating a new registry. To accomplish this, FEMA and the DHS Office of the Chief Procurement Officer are working with the Office of Federal Procurement Policy to incorporate the capability of searching for and locating local businesses in an area affected by a disaster and their bonding levels. CCR will have the capability to locate local businesses based on the county they are located in, by zip code, by Metropolitan Statistical Area, as well as area code. Businesses registering in the CCR will also provide their boding levels. These enhanced capabilities will ensure that the requirements of section 697 are met and that the Federal government relies on a central database and avoids the possible confusion that may result with its industry partners.

e. Section 698

Section 698 requires the Administrator to develop and implement a program to provide training on the prevention of waste, fraud and abuse of Federal disaster relief assistance relating to the response to or recovery from natural disasters and acts of terrorism or other man-made disasters and ways to identify such potential waste, fraud, and abuse.

The National Processing Service Centers (NPSC) play a vital role in helping the agency prevent fraud, waste and abuse.

- All NPSC caseworkers receive training in Duplicate Investigation and Duplicate Resolution. This training prepares NPSC staff to investigate and resolve situations where more than one registrant reports duplicative data. Each case is examined to determine if the registrations are in fact duplicates, and if so, to cancel the appropriate registration so that duplicative payments are not made.
- NPSC caseworkers receive extensive training on FEMA's identity, occupancy and ownership verification requirements. NPSC caseworkers are all well-informed of the documentation required of applicants to prove these basic eligibility requirements and disaster assistance awards are withheld until the applicant provides them.
- Training is provided to NPSC caseworkers assigned to Recoupment assignments on fraudulent document identification and the procedures for notifying the authorities when such cases are uncovered.

General Management

11. **What is your approach to managing staff, and how has it developed in your previous management experiences?**

First, it is important to draw a distinction between "managing staff" and "leading staff." As the Deputy Administrator for FEMA, it is my responsibility to do both. I am principally responsible for implementing Administrator Paulison's Vision for New FEMA. In that capacity, I devote a significant level of attention to creating, framing and describing the details of that Vision to senior staff and others inside and outside of FEMA, and then leading FEMA staff on the pathway to attain that Vision. This is an ongoing responsibility and is accomplished through discussion, coaching, encouraging, tasking, reaffirming and, in some cases, taking personal charge. I meet with key leaders individually and in group sessions, often ensuring that they are accompanied by their senior staffs. Together, we have taken on initiatives such as the establishment of the Vision; conducting the 17 Business Process Assessments; implementing the Gap Analysis; instilling a new budget process; and striving toward 95 percent staffing. Each of these provided opportunities to lead FEMA to destinations that many initially thought unattainable. And, each has contributed to building a new culture and restoring a sense of pride and accomplishment. This has not been simply a personal effort as other key leaders (Ms. Deidre Lee, Mr. Marko Bourne, Mr. Bob Shea, Mr. Dennis Schrader) have been and continue to be instrumental in supporting Administrator Paulison in leading to achieve the New FEMA.

In the conduct of daily business and in the process of implementing FEMA's leadership initiatives, I am also responsible for managing the FEMA staff. Managing staff means that I work directly and through others to instill a sense of structure, order, integration and process, and set very high expectations for quality, responsiveness, farsightedness and intellectual content. This also involves managing FEMA staff interactions within FEMA as well as managing interactions and partnerships with DHS and other essential departments and agencies, councils, associations, non-governmental organizations, private sector entities and individuals. And, it includes oversight of FEMA's engagement with Congress. To best ensure that the staff is well managed, I engage with key leaders and their staffs through many meetings and discussions. These meetings can be one-on-one, but are generally very well attended, and always include an

opportunity for every individual in attendance to have an opportunity to contribute. I am clear in my verbal and written instruction, and am always approachable with an open door and daily schedule that generally runs up to fourteen hours each day.

12. **The Post-Katrina Act, which was passed to address the failed response to Hurricane Katrina, strengthens and reforms FEMA and among other things, reorganizes aspects of the Department to enable DHS to more effectively fulfill its emergency management mission. This includes rejoining the preparedness and response functions within FEMA.**

    a. **What management challenges have you faced and will you face in the implementation of the Post-Katrina Act? What are you doing and will you do to address those challenges?**

The transfer of preparedness missions from the former DHS Preparedness Directorate will improve the abilities of FEMA to provide more comprehensive emergency management services to the Federal government and its State, tribal, territorial, and local government stakeholders. The management challenges associated with the transfer have also helped to improve FEMA's quality of service. Those challenges include mission integration, consolidating business processes as well as structuring the workforce and hiring to fill vacancies.

Like any organizational change, the influx of new missions and requirements requires personnel to both perform and support those missions. For example, the transfer of several hundred preparedness positions and the missions performed by those individuals into FEMA continues to be a huge administrative undertaking that has significant implications to human resources, information technology systems, facilities, financial and procurement operations, external affairs, and oversight operations. FEMA worked closely with Department Headquarters to organize nine business function teams to manage the transition of each of the administrative support services to FEMA. Most FEMA support offices, while assuming a large increase in work load without additional resources, are continuing the process of integrating email systems, budget development and personnel recruiting. For example, over 600 personnel were transferred from the former Preparedness Directorate with separate email systems, financial accounting systems, over half a dozen separate web portals, more than 20 percent vacancy rates and no business support staff or offices.

FEMA took this as an opportunity to re-examine and perform updates to its total organizational alignment to include a mission and function review of organizational structures, alignment of personnel and institution of new budget development procedures. As a result, the Agency's infrastructure, both at FEMA Headquarters and at the Regions, is now better positioned to support a larger organization. Also, I am very proud of the pace in which we have hired new people to maintain a high staffing rate for its permanent full-time positions. This next year will require further refinements to address redundancies and fully merge preparedness administrative functions with those of the rest of the Agency.

b. **What measures will you take to ensure that preparedness functions you will oversee will be properly integrated into FEMA? What difficulties have you encountered and do you anticipate in re-integrating the preparedness functions with FEMA, and how have you and will you address them?**

The broadened preparedness mission within FEMA and its Regional offices provide the Federal government with an unprecedented opportunity to better organize and coordinate all aspects of the Nation's homeland security posture. The integration of preparedness functions in FEMA involves both programmatic and administrative integration efforts in the areas of strategic policy, grants, planning, training, and exercises, to name a few.

The National Preparedness Directorate (NPD) will be FEMA's leader in the design and implementation of the National Preparedness System. The System shall include development of preparedness policy, doctrine, oversight of program implementation by the Regions, and analysis of outcomes for all hazards preparedness across the Nation. This includes the Federal interagency, State, local, tribal, private sector, and non-governmental organization preparedness. In addition, the NPD National Integration Center combines new and existing FEMA training institutions and programs and will help apply a common standard to the design, development, and delivery of the full scope of training and exercise activities.

For the first time, DHS has a dedicated grants management organization – FEMA's Grant Programs Directorate (GPD) – that will apply a common administration framework for both disaster and non-disaster grant programs. GPD's critical mission will be to assist grantees in employing risk management frameworks as developed by NPD to achieve homeland security capability targets, while also providing a unified approach to Federal financial assistance management in support of FEMA's multi-faceted mission and customer base.

Also for the first time, DHS will have an established regional structure for delivering preparedness assistance and interacting with State, tribal, territorial, and local government, private sector, and community stakeholders. The co-location of preparedness assets and programs at the ten FEMA Regions is a key element in our efforts to integrate new and existing preparedness programs at FEMA. Their co-location at the Regions will not only ensure a close working relationship with an expanded scope of stakeholders, but also ensure that homeland security preparedness efforts are closely linked with response and recovery operations.

The most significant challenges experienced to date have been the consolidation of many different grant program and business functions, and extending the implementation of preparedness activities out to the Regions. These challenges are being addressed through the hiring of new personnel at the Regions such as Federal Preparedness Coordinators and a detailed analysis and mapping of consolidated grant processes. This difficult work is anticipated to result in a more cohesive and uniform framework with which the Federal government delivers preparedness assistance across the Nation.

13. **Over the last year, as required by the Post-Katrina Act, which among other things called for an organizational transformation, DHS has reorganized its emergency preparedness and response programs. When DHS was first stood up, the Government Accountability Office (GAO) identified key mergers and transformation practices and implementation steps, such as setting goals and a timeline and establishing a communications strategy, to help agencies, like DHS, implement successful organizational transformations.**[1]

    a. **Regarding this reorganization, to what extent is FEMA following GAO's advice?**

FEMA has undertaken a long term process for change management and transformation that began before PKEMRA was passed. This process included a number of assessment initiatives to develop a better understanding of FEMA's business practices and organizational needs, including the reorganization of FEMA's structure and the integration of the elements of the former Preparedness Directorate. A full scale effort involving nine tiger teams on major mission and functional areas was established to address the immediate merger and transformation activities. We established within the Office of Policy and Program Analysis a Transformation and Transition Office to oversee this complex process. The tiger teams worked on a variety of issues ranging from merging payroll information and position transfers to larger structural and programmatic alignments. This process continues. We continue to review our expansion of the Regional Office activities and are doing full-scale analysis of the relationships between program offices at headquarters and the Regions. We have also been developing metrics for both internal to headquarters and Regional Office programs and activities. We have also instituted a Program Analysis and Evaluation Branch to address programmatic reviews and metrics. We have hired full-time staff to support and lead these transformational activities.

    b. **What sorts of performance metrics do you think would be most realistic and useful to assess the effectiveness of the reorganization?**

The best metrics we can apply to FEMA through this reorganization effort will be evidenced by improved business practices, customer services, programmatic reviews and assessments. For example, prior to the reorganization and the institution of hiring metrics, FEMA had a 75 percent on board rate for full time employees. Through a major program of restructuring our hiring practices and procedures and our implementation of new recruitment programs, we have achieved a better than 95 percent on board rate and are holding at that level. That metric will continue to be a benchmark for FEMA. Additional metrics include increasing the number of training and exercise opportunities we can provide to our State and local partners and for the professional development of FEMA employees. Procurement metrics are also important. In Fiscal Year 2006, FEMA awarded approximately 54 percent of its contract actions using competitive procedures, ranking last among all DHS components. However, due to the initiatives implemented by the Office of Acquisition Management, FEMA competitively awarded approximately 70 percent of its contract actions in fiscal year 2007, ranking second among all DHS contracting components. Additional metrics are being developed for budget

[1] GAO, *Results-Oriented Cultures: Implementation Steps to Assist Mergers and Organizational Transformations*, GAO-03-669 (Washington, D.C.: July 2, 2003)

development, investment reviews, programmatic effectiveness, readiness contracting, ability to support response operations faster and more efficiently and also streamlined disaster assistance to victims.

c. What roles are the FEMA regions playing in this transformation? What new responsibilities do they have for daily operations and program implementation?

The FEMA Regions play a critical role in this organizational transformation. The Region is the essential field echelon of FEMA that engages most directly with State partners and disaster victims to deliver frontline services. It is the Region that can build and nurture State and local capabilities across the spectrum of preparedness, response, recovery and mitigation. It is the Region that will lead the Federal response to incidents across the spectrum of all-hazards events. A strong FEMA will rely on strong Regions to regain the trust and confidence of Governors, mayors, leaders in the private sector and the citizens of our homeland.

d. The Committee understands that FEMA has commissioned studies of 18 areas within FEMA, including areas such as contractor management program, finance center operations, capital planning and investment control, human resources, logistics, acquisition, etc. Which areas have been studied? Please provide the results of these studies. Have these studies met your expectations? How are you integrating the results of these studies into your efforts to create the new FEMA required by the Post-Katrina Act?

FEMA conducted a series of agency-wide assessments of its capabilities and internal structure, to identify mission critical existing and needed competencies, responsibilities and gaps. A total of 17 assessments were conducted and covered the areas of Acquisition, Budget Process, Capital Planning Investment Control, Contracting Officer Technical Representative, Data Resource Management, Disaster Emergency Centers, Disaster Relief Fund, Disaster Workforce Study, Facilities, Federal Coordinating Officer Cadre, Finance Center Operations, Finance System, Human Capital, Individual Assistance - Technical Assistance Contract, Information Technology, Logistics and Security. The results of the assessments have met my expectations and the recommendations are being integrated to make FEMA the Nation's preeminent emergency management agency.

Assessment findings that were consistent through all areas assessed were:

- FEMA employees are hard working and dedicated employees ready for transformation;
- High turnover and high vacancy rates exist in leadership positions;
- Heavy workloads force staff to be tactical rather than strategic;
- There exists a lack of documented and standardized repeatable processes;
- Internal controls, policies and procedures were found to be limited, outdated or non-existent;
- FEMA's culture was found to be transaction focused and reactive rather than proactive; and
- Antiquated or manual processes for basic support services were well behind industry standards.

Many recommendations were made to improve business processes, cross-organizational communication, and accountability. FEMA also recognized the need to boost staffing levels and add value to customer services.

Some of the major results of the Assessments are:

- FEMA reached 95 percent of authorized staffing levels on June 21, 2007;
- An "Orientation Central" is in place for new employee orientation;
- Several divisions have reorganized to more accurately reflect the needs of the organization, and to streamline operations;
- One-Stop Badge and the Fingerprint Office streamlines both functions and provides improved customer service;
- FEMA now uses full electronic processing of applicant and employee fingerprints sent to the FBI;
- Elimination of Katrina/Rita backlog of 10,000 background investigations (staffing) reduced to under 2,000 and met current OPM and HSPD -12 requirements – backlog should be completed by December 2007;
- FEMA is submitting 100 percent of all new Background Investigations to OPM via E-QIP (Electronic Questionnaires for Investigations Processing);
- The IT organization is aligned with mission support function and is evolving to a more service oriented organization; and
- A facilities help desk was established.

FEMA has integrated the results of the assessments to contribute to a result-oriented business approach, bridge the gap with industry/government best practices, and enhance FEMA's mission and success. The changes that have been made in the organization will ensure that the Agency can support the New FEMA's goals.

14. **In approximately 15 months, there will be a new presidential administration and, presumably, new leadership of the Department of Homeland Security. What actions do you intend to take to ensure that there is a smooth transition and that FEMA is operating, and will continue to operate, effectively through the transition?**

FEMA has begun transition planning and assigned the overall transition effort to the Transformation/Transition Branch of the Office of Policy and Program Analysis. This staff will coordinate the transition activities of all the FEMA directorates and offices and interface with DHS' transition program. It will also be important to train all incoming appointees on the National Response Framework, the National Preparedness Guidelines, the Robert T. Stafford Disaster Relief Act; Homeland Security Presidential Directives; and the National Homeland Security Strategy, just to name a few. In addition, FEMA will develop briefing materials and training to address many of the following areas:

I. Informational Activities
   a. Agency Organization

i. Organizational Structure with functions
ii. Succession Planning
1. Data call and analysis
2. Training/education
3. Personnel movements to fill gaps
iii. Points of Contact / SOPS

b. FEMA-wide Handbook
i. Description of New FEMA
ii. Listing of reference materials: (Strategic Plan, relevant policies, management directives, MOUs, CONOPS, Doctrine, etc.)

c. Mission Critical Functions (including overview, process, delegations of authority, POCs within FEMA, POCs outside FEMA)
i. Disaster operations
ii. Declaration process
iii. Disaster Assistance and Grant awards process
iv. Exercises
v. Executive Communications/Alert and Warning
vi. COOP/COG

d. Budget
i. Funding history
ii. Budget and financial processes (including how and when to access funds)
iii. Fiscal Year 2009 Budget

e. Procurements
i. Contracts Anticipated to be executed
ii. Impending Contract Deadlines
iii. Facility Leases

f. Ongoing Change Initiatives (with high-level overview, timeline, major milestones, POCs)
i. IMATS
ii. Regional-National Preparedness
iii. Investment Working Group process
iv. Policy process
v. Logistics Management
vi. IFMUS
vii. Enterprise Architecture
viii. PRISM
ix. Email integration
x. Regional Space Initiative

g. Briefing Sessions
i. Briefings for FEMA career and political personnel
ii. Briefings for candidates
iii. Briefings for incoming Administration officials

II. Implementation
a. Roles and Responsibilities matrix
b. Timeline for performance
c. Compliance with Transition Plan

d. Appropriate conduct of outgoing and remaining employees
e. Authorizing decision making for certain critical functions to be performed at a lower level on a temporary basis
f. Formalizing informal agreements
g. Preserve objectivity

15. **Do you believe that FEMA is currently making appropriate use of contractors, or that it is over or under utilizing contractors? If confirmed, what factors would you consider in determining whether or not to use contractors for particular professional and management support services in FEMA, and how would you weight those factors?**

Yes. While the Agency's responsibility and mission in disaster preparedness, protection, response, recovery and mitigation is vast and expansive, FEMA's workforce is made up of only approximately 2,600 permanent full time (PFT) employees. Post-Katrina, FEMA set a goal to make tremendous progress in hiring and recruiting, and since then, we have made great advancements in increasing workforce capacity.

FEMA also maintains a surge capacity of Disaster Assistance Employees (DAEs). These surge employees have expertise in a number of functions important to disaster response and recovery functions including: contracting, environmental policy, engineering, legal support, and financial management.

When the expertise to accomplish FEMA mission-critical functions does not exist within the Agency's full-time staff or surge employees, FEMA regularly relies on our Federal partners. Through planning efforts established in various working groups, through mission assignments, and in times of active disaster response, FEMA taps into subject matter experts across the spectrum of disciplines to gain technical expertise and charges these agencies with responding to the disaster need.

After evaluating the availability of expertise within and at the Federal level, FEMA then evaluates the use of industry support for particular professional and management support services. In many cases, industry can provide a particular knowledge base to address a mission need in the Agency's program and support organizations. For example, FEMA regularly uses Individual Assistance Technical Assistance Contracts (IA-TAC). These contracts permit flexible solutions to housing, mass care, and other disaster related requirements. As an example, contractors may be asked to manage (installation, haul, install, set-up) the temporary housing operations for applicants after a disaster declaration, both for private and group sites. This readiness capability ensures that FEMA is able to readily meet the disaster housing needs of affected individuals quickly.

FEMA's mission requirements are highly volatile, fluctuate from year to year, and are affected by the quantity, frequency, and severity of disaster activity. When determining the use of such industry support, FEMA considers factors such as efficiency, effectiveness, and timeliness of service delivery.

16. **This month, wildfires wreaked havoc in Southern California, forcing hundreds of thousands to flee their homes. On October 25th, you led a press conference about FEMA's response to the wildfires at which there were apparently no journalists present. Rather than proceed with just a press statement, FEMA opened the session up for questions even though only FEMA employees were present to question you?**

a. What role did you have in determining the format of the press conference?

I did not have any role in determining the format of the press conference.

b. Why did FEMA only give the press 15 minutes notice for the press conference?

It was a very serious mistake for FEMA to give the press 15 minutes notice. As with many things during the response phase to a Major Disaster, many actions are planned and executed in very short timeframes. The decision to hold a press conference was based on a desire to provide real-time information about the ongoing response to the California wildfires and to respond to a high number of press inquiries on the response. The press conference was held immediately after a Video Teleconference that included FEMA personnel, key Federal partners and representatives from the State of California. Unfortunately, the time between the decision to hold the press conference and the time set for the event was so thoughtlessly compressed that it adversely affected every other planning element.

The amount of time provided to the media was inadequate to ensure participation. We recently remedied the potential for such an event to recur by establishing FEMA Press Event Standard Operating Procedures (SOP). These procedures have addressed this matter. Going forward, FEMA will try to notify the media at least two hours prior to the start of a press conference, but at a minimum, no less than one hour prior to any press conference.

c. Why weren't journalists on the phone allowed to ask questions?

During the response to Hurricane Katrina, FEMA hosted regular media question and answer sessions via telephone. These sessions frequently included over 100 media outlets who requested to listen in to the press statements and be given an opportunity to ask questions. However, when that many people are on a single conference line, background noise, static, open phones, etc., frequently cause confusion and make it difficult to hear. Based on that experience, FEMA began using "listen only" conference lines to allow media that could not be present at press statements and press conferences in person to listen to what was being said without the resultant background noise from an open line. Unfortunately, this practice continued and was used for this press conference, even though technology allowed for a better solution

This practice of using "listen only" lines has been abolished. The newly established SOP requires conference lines for every press event so that the media can fully participate.

d. Either before or during the press conference what was your understanding of who the individuals were that were asking you questions during the press conference? Did you know they were FEMA employees?

Based on a late morning briefing by the Director of External Affairs, I agreed to and expected to conduct a press conference with media representatives following a video teleconference for the California wildfires. I was prepared to begin with a summary of the current situation and then to respond to questions. Upon arrival at the press center, there was a short pause to reaffirm the plan to provide a summary and take questions. I do not recall any discussion advising me that the media was not represented or that FEMA personnel would be asking the questions. Upon entering the press center, I noted that most of the seats were filled, some with FEMA employees that I knew, and some with other persons who I did not know and presumed them to be media representatives. I was comfortable that the forum appeared as I expected it to be. Six questions were asked one at a time. The first five came from FEMA employees. As each question was being asked, I was expecting others in the room to begin to ask questions. The last question was from a person I presumed to be a media representative. As I learned later, the last questioner was in fact a FEMA employee.

e. Why did FEMA decide to proceed with a question and answer session with FEMA employees asking the questions?

The conduct of a press conference in such manner was mistake that will not be repeated. FEMA's new SOP prohibits FEMA employees from asking any questions at a press conference.

While there is no justification for the conduct of the press conference, the explanation is that those directing the event were trying to provide accurate information in near real time for a major emergency. The decision to proceed (as opposed to delay in order to allow the media to arrive) was clearly a regrettable error in judgment.

Though scheduled with little notice, FEMA External Affairs staff anticipated that media would nevertheless be present at the press conference given the high profile nature of the event. However, when none arrived, the FEMA Press Secretary made a last-minute and incorrect decision to require FEMA staff to ask questions. The decision resulted from a lack of sound management and oversight of the event and poor judgment at key decision points, driven by a sincere feeling that there was a need to present additional information in a timely manner. The questions asked had been posed to FEMA by the press during the course of that day, and all of the responses were accurate. I want to assure you that this was an isolated incident, and in no way reflects or is consistent with our standards for engaging with the media.

Personnel

17. **An initiative noted by Secretary Chertoff is to train employees from across the government to be "disaster generalists" in order to augment surge capacity. Additionally, in answers to policy questions for his nomination as FEMA Director, FEMA Administrator Paulison said that if the scope and magnitude of a disaster warrants it, FEMA will augment its disaster workers by deploying DHS employees, members of the Coast Guard Auxiliary, and firefighters.**

    a. **How specifically will such a program operate, e.g., selection of employees, geographical location, initial and ongoing training, reporting authority, evaluation and responsibility for ESF functions? What is the current status of such program?**

A critical aspect of achieving the Vision for New FEMA and improving disaster response capabilities is developing and maintaining a trained and effective disaster workforce that can provide FEMA the capability to surge an adequate number of disaster workers when needed to provide critical support to State, local, and tribal governments. A long-standing FEMA priority has included reexamining, restructuring and improving the disaster workforce to bring its operational capabilities into closer alignment with FEMA's strategic goals and objectives; improving disaster response times; and ensuring quality delivery of services through improvements in systems, management structure, and workforce development. The importance of this priority activity was emphasized in PKEMRA.

FEMA currently is studying different approaches for creating a single, standardized system for developing, deploying and maintaining accountability of the disaster workforce. A major goal of the Disaster Workforce Management Initiative is to develop a more highly trained and effective disaster workforce with greater focus on skill development and credentialing of cadres and teams. A critical component of the disaster workforce is an adequate sized Disaster Generalists workforce that the Agency can call upon to provide surge capability. Different options for staffing the Disaster Generalist pool are under review as part of the study, including possibly drawing from components of DHS, the fire community, the Coast Guard Auxiliary, and other departments and agencies.

Different options for training are being examined as part of the ongoing study ranging from in-house to distance learning. For this year's hurricane season, for example, Disaster Generalists already rostered were provided hard copy training materials pending the availability of additional funding for the development of more detailed training. Possibilities for training include in-house training at the Emergency Management Institute and training via the internet. Additional funding will be required to fully implement disaster surge workforce activities.

    b. **How many DHS employees, members of the Coast Guard, and firefighters have been included in the Disaster Assistance Employee Surge workforce? How many of these individuals have received training for possible deployment?**

The deployment database identifies 1,154 active Disaster Assistance Employees (DAE) who fall into one or more of the above listed categories - 168 from the Coast Guard Auxiliary and 986 from the volunteer fire fighter community. Other than those identified, there have been no DHS component employees trained to date.

18. **Failure to have enough trained personnel is one of the problems identified in the Committee's report, "Hurricane Katrina: A Nation Still Unprepared," on the response to Hurricane Katrina, including the failure to have enough employees to staff emergency response teams and inadequate staff to run the National Resource Coordination Center (NRCC), the Regional Resource Coordination Center (RRCC), and Joint Field Office (JFO).**

    a. **What percent of FEMA's appropriated full-time permanent staff positions are currently filled?**

FEMA achieved a 96.8 percent fill rate of the authorized Fiscal Year 2007 base through September 30, 2007.

    b. **If you are confirmed, what steps will you take to ensure that FEMA has enough employees on board to run twenty-four hour operations for the duration of critical hours of a response in the following:**

    i. **NRCC;**
    ii. **RRCC; and**
    iii. **JFO?**

To achieve the Vision for New FEMA, the NRCC and the ten RRCCs must have staffing and communications capabilities to maintain complete situational awareness in their respective locations.

In the case of the NRCC, this capability will be achieved by having a facility with the right tools to maintain complete national situational awareness and the proper number of personnel to support 24/7 operations. At the present time, the NRCC is staffed 24/7 with four watch teams of 5-6 members each. This level of staffing is achieved with a combination of permanent full-time employees, Katrina CORE and contract personnel. The NRCC has been authorized additional positions: 6 GS-12 Watch Analysts, 3 GS-13 Senior Watch Analysts and 1 GS-14 Watch Officer. FEMA Human Resources is working with the Disaster Operations Directorate to fill these positions as quickly as possible and currently four of the positions should be filled with staff reporting. The extra time is necessary because the new watch officers are now required to have clearances and time is needed to complete the adjudication process. These additional ten positions will provide the ability for the NRCC to establish five watch teams and to respond to any incident in the initial stages of development. The fifth watch team will provide "surge" capability, offering the Disaster Operations Directorate another method of monitoring a situation without requiring full activation of the NRCC at Level III.

At the ten RRCCs this capability will be achieved by having a facility with the right tools to maintain a 24/7 watch operation. The RRCCs will require personnel to maintain a state of readiness in order to perform the responsibilities assigned. For normal watch operations or for periods of activation with an augmented staff, the Region's Response and Recovery Division Director will ensure that the RRCCs are staffed with trained personnel who are proficient in maintaining situational awareness, engaging with other operations centers, and providing analysis of ongoing events for their chain of command. Additionally, the RRCC must be capable of conducting preliminary planning efforts and initiate forward-leaning, proactive courses of action to meet expected or impending events. Operational planning support should be made available to the watch as appropriate. Each RRCC will have a Watch Officer and a Watch Analyst.

In Fiscal Year 2007, the NRCC and RRCCs began the transition to procure equipment, modify facilities, and obtain appropriate security clearances for their personnel. As we increase the number of personnel staffing the NRCC and the RRCCs, the personnel will need to maintain situational awareness using a variety of sources. Situational awareness can be maintained using commercial and government available software, connections with State and/or local EOC's, and capability to observe news media outlets to monitor breaking events.

To assist the NRCC/RRCCs/JFOs in managing operations, improving information flow, maintaining situational awareness, and coordinating information sharing, we have recently procured our Emergency Management Information Management System (EMIMS). Its operational deployment to the NRCC by the end of November/ mid-December 2007 timeframe is on schedule.

Since EMIMS is designed to link directly into the Homeland Security Information Network, passing information to DHS should be significantly smoother and more efficient. In addition to its own graphic interface, EMIMS will also integrate into iCAV, the DHS standard GIS application, and the associated iCAV databases. One of the additional features of EMIMS is its ability to pass information to and from the commercial software packages currently in use by State and local governments. As part of the delivery to the NRCC, EMIMS will be integrated into the WebEOC system in use within the National Capital Region. As we deploy EMIMS to the Regions, the vendor will also link it to software packages used by the states and major urban area emergency managers.

The RRCCs, with their refined capabilities, will enhance FEMA's ability to stay abreast of all late-breaking events, to maintain situational awareness across all of FEMA in any designated area of the country 24 hours per day.

The new emphasis on FEMA's ability to operate in an all-hazards environment results in the requirements to be capable of conducting preparedness, protection, response, recovery, and mitigation operations supporting national security, natural disasters, acts of terrorism, and other man-made disasters, including catastrophic incidents. Adding these capabilities will also facilitate improved situational awareness and connectivity with other Federal partners.

c. **FEMA's poor performance in responding to Hurricanes Katrina and Rita was due, in part, to the lack of a sufficient number of trained acquisition personnel. As such, FEMA often found itself too shorthanded to clearly define its requirements, negotiate sound business arrangements, and effectively monitor contractor performance. What actions has FEMA taken to identify, recruit and retain such individuals? Are there particular skill sets that remain in short supply?**

The Office of Acquisition Management (OAM) at FEMA utilizes a variety of recruitment strategies to recruit and retain acquisition professionals, which has resulted in a staffing level of 90 percent. As of October 2007, OAM has a total of 176 full time employees and has created a separate Gulf Coast acquisition office which has 63 positions, bringing the total staff to 239. As of October 2005, Pre-Katrina, the staffing level of the organization was at 35.

The staffing levels mentioned above were achieved using multiple successful recruitment strategies, which ensured that FEMA had a strong acquisition workforce to support its mission. The direct hire legislation for 1102 series workforce was the most successful strategy enabling FEMA to quickly hire personnel. This legislation expired on September 30, 2007 and is no longer available to DHS.

FEMA also utilized recruitment and relocation bonuses to attract new employees and offered referral bonuses to existing employees upon the hiring of a new referred employee. FEMA also participated in and hosted multiple DHS and FEMA job fairs where it successfully hired several highly-qualified acquisition professionals. In addition, FEMA is taking part in a DHS intern program through actively participating in the coordination, recruitment and interviewing efforts, as well as preparing mentors to work with the interns when they arrive in January 2008. This program offers talented and motivated candidates the opportunity to participate in a three-year development program with rotations through the acquisition offices of several DHS components, including FEMA. Throughout the course of the intern program, participants gain 400 hours of acquisition training and 100 hours of leadership-specific training. Upon successful completion of the program, interns gain experiences needed by acquisition personnel and are offered full-time positions upon successful completion.

In addition to recruitment strategies, FEMA makes significant efforts to retain employees, through the use of training and development opportunities. Each employee has prepared an individual development plan that reflects professional and career development opportunities. Employees are also awarded monetarily with on-the-spot awards, performance bonuses, and time-off awards.

Lastly, FEMA has instituted an acquisition skill gap, which evaluates the contracting workforce by reviewing current skills and identifying those that will be needed in the future. Areas of consideration include number and type of positions required because of mission change, new technology, or other requirements. This involves anticipating turnover rates due to extremely heavy workload, the unpredictable workload of supporting disaster activities, and the increase in performance based contracting and demand for contract oversight/administration.

19. **The Committee's Katrina investigation revealed inadequacies in FEMA's surge workforce for disasters such as a failure to have enough trained Disaster Assistance Employees (DAE) that arrive in a timely manner. How many individuals does FEMA currently have in its DAE cadre? What training have DAEs received during the last 12 months? What improvements have been made in the DAE? Please describe in detail.**

As of October 25, 2007, there were a total of 8,110 DAEs registered with FEMA. During Fiscal Year 2007, 51 resident training courses were scheduled for DAEs and over 6,000 individuals participated in Independent Study Courses.

To improve FEMA's response capability, FEMA added 4,000 new temporary employees after Hurricane Katrina: 1,000 to serve in existing disaster response cadres as well as 3,000 to provide a surge capacity workforce. The 3,000-employee surge capacity workforce, in addition to the permanent and term appointment employees, help meet the need to have a trained, readily available pool of disaster workers capable of performing a number of basic but important tasks during disaster response and recovery operations. The management and organization of this workforce is now being restructured to place greater focus on training, employee skill sets and knowledge development, credentialing of cadres and teams, deployment of personnel, and tracking and reporting on the status of personnel deployed in disaster response. The end goal is to create a surge capacity workforce and to establish a single and standardized system for managing, deploying, and maintaining accountability of FEMA's entire disaster workforce.

Most recently, to address the PKEMRA requirements and development of an appropriately-sized and trained surge workforce, FEMA contracted with Booz-Allen-Hamilton (BAH) to conduct a strategic organizational assessment of and to comprehensively and rigorously examine FEMA's "intermittent disaster workforce approaches." The BAH assessment examined current workforce capabilities, analyzed future workforce requirements, developed best practices recommendations based on other organizational staffing models, and identified state-of-the-art information technology needs to support the disaster response program. The assessment recommendations will be incorporated as appropriate, into an initial draft "Surge Capacity Force Plan" scheduled to be completed by December 30, 2007.

Different options for training are being examined as part of the ongoing study ranging from in-house to distance learning. For this year's hurricane season, for example, Disaster Generalists already rostered were provided hard copy training materials pending funding for the development of more detailed training. Possibilities for training include in-house training at the Emergency Management Institute and training via the internet.

In addition to the BAH assessment, related activities are either planned or already underway that will support surge capacity disaster workforce development. These include:

- Establishing a disaster workforce Assessment Advisory Workgroup to review and provide input into the development of a more effective disaster workforce;

- Pursuing opportunities to recruit disaster generalists from DHS components such as the U.S. Citizenship and Immigration Services (USCIS) and from other groups of individuals such as the Coast Guard Auxiliary and the fire community;
- Coordinating with DHS components to access specialized disaster response support;
- Exploring options to provide employee protections/benefits to broaden the pool from which a surge capacity force can be recruited;
- Considering incentives such as health insurance (currently unavailable to select temporary employees) and some level of benefits to attract additional staff for the surge workforce;
- Developing additional training for the disaster surge workforce; and
- Upgrading the Automated Deployment Database and associated communications system to enhance the notification and response times of disaster workers.

Personnel Management

20. **What actions in your past executive experiences demonstrate your style and approach in the area of labor-management relations?**

My past executive experience stems from thirty-one years as a Coast Guard officer, with the last five years as a Flag officer. During that period, my view on the relationship between labor and management was largely formed from the perspective of a helicopter pilot interacting with an aircrew man. In that relationship, mission success demanded an interdependent relationship, where there is professional respect one to another; where open and clear communications were an imperative; where there was no differentiation based on sex, racial origin or any other discriminatory element; where each demanded the best of the other; and where both could walk away after a successful landing and want to come back and do the mission again. During the flight, we could banter during the transit periods, yet focus with intensity over a boat or with a person in the rescue basket. We often came from uncommon backgrounds, had different levels of education and experience, and perhaps shared little in common away from the aircraft or air station, but we were teammates. As an aircraft commander, it was my responsibility to set the tone and parameters, and to ensure that our team performed well on every mission.

As an executive in the Coast Guard, and now with FEMA, I carry that same approach and perspective in labor-management relations. It is my responsibility to establish an environment that will lead to team success. It requires respect, effective communications, fair demands one to another, shared objectives, human understanding and no tolerance for discrimination of any sort. And these elements are required consistently in every relationship, every day.

21. **This Committee's investigation of Hurricane Katrina found that training of various teams within FEMA was sorely lacking. For example, the Emergency Response Teams at FEMA rarely trained or exercised together.**

    a. **If confirmed as Deputy Administrator for FEMA, what do you envision as your role for ensuring that personnel within DHS receive adequate and meaningful training and exercising?**

In accordance with a range of policy and statutory authorities, FEMA has responsibility to develop, field, and maintain the operation of a National Training Program (NTP), a National Exercise Program (NEP), the National Incident Management System (NIMS), and the National Response Framework (NRF). These integrated programs provide the wide-ranging authority and basis to establish and conduct a comprehensive network of individual, collective, and organizational training and exercise activities.

Much has been accomplished to develop each of these important and unprecedented programs. The National Preparedness Guidelines (NPG) have been developed and recently released. The Target Capabilities described in the NPG establish, for the first time, a baseline set of needs for jurisdictions and agencies to organize procurement, training, and exercise activities. Similarly, the codification and release of the NEP continues to improve the coordination of preparedness activities of the homeland security community. The NEP provides the tools to systematically plan, organize, conduct, evaluate, and report on exercise activities. The NIMS defines a full range of incident management and enabling activities in the area of resource classification and type classification, credentialing, and related training. The NRF updates and extends the precursor National Response Plan by providing an overall framework description supported by a suite of interactive products tailored to specific communities–all of which must be proficient in the principles and procedures described in the NRF. When fully implemented, the NTP will integrate all preparedness-related training and exercise activities, streamlining our Nation's educational resources and improving preparedness levels overall.

In the past, departments and agencies (even within DHS) have approached the training and mandated proficiencies of their respective personnel management programs with an inward focus. While such a practice allows each agency to meet its internal training and proficiency needs, internally focused training can also lead to shortfalls in multi-agency activities where a truly integrated and timely response is paramount to overall success. As such, it falls upon FEMA to work in conjunction with Federal agencies, intra-DHS, State, local, tribal, and private sector partners to identify and integrate existing resources that are currently dedicated to training and exercise activities. The collective buy-in, coupled with the approval of the President, of the NEP (and eventually the NTP) will enable FEMA to integrate training and exercise activities beyond the scope of just one department or agency, linking these efforts across the United States government.

Resources within FEMA dedicated to these critically important tasks reside primarily, but not exclusively, within the newly created National Integration Center (NIC), a component of the National Preparedness Directorate (NPD) that is overseen by the leadership of Deputy Administrator Dennis Schrader. The NIC incorporated once disparate training and exercise entities under one managing office. These agencies are: the Emergency Management Institute, Center for Domestic Preparedness, Incident Management Systems Branch, National Exercise Division, and Training/Education Integration Center. Each of these components that came together as a result of PKEMRA brings essential assets that will unify to achieve the objectives of the full range of programs described above. Actions are currently underway to fully integrate the personnel, resources, and capabilities resident in each of these critically important preparedness driving organizations.

Integration of preparedness efforts occur at several levels, through various programs established and maintained by elements within the NIC. There are several specific examples of systematic efforts currently underway. In the area of training resource integration, the NIC has initiated a project to reconcile current differences in systems used to coordinate training activities. The vision for this particular effort is to end up with a single access point through which Federal, State, local, tribal, and to the degree authorized, the private sector, can reach a consolidated list of training courses. This approach is intended to include standardized registration and a unified means to provide support to the students. In the area of exercises, there are several tools that have been developed and fielded that provide a means for exercise coordination to be both standardized and better synchronized. The recent deployment of the Corrective Action Program as a companion to the Lessons Learned Information Sharing system provides the entire homeland security community with a standardized approach to observing, assessing, assigned for action, tracking, and reporting on lessons learned and best practices. The NIC is working closely with the DHS Chief Learning Officer (CLO) to further integrate our training efforts and career development paths for the Department's employees.

As Deputy Administrator, I view my role as guiding the efforts necessary to achieve the intent of the integrated preparedness cycle through collaboration and coordination with the Deputy Administrator for National Preparedness. I will continue to be a strong advocate within FEMA, DHS, the Inter-agency, with State, tribal and local partners and the private sector to ensure the entire homeland security community participates and benefits in the development and execution of these preparedness programs.

b. How will you ensure that FEMA's emergency response teams are prepared?

The emergency response teams must be properly staffed, equipped, and have a clear mission and purpose. This occurs through a focused and comprehensive training program that engages Federal, State and local partners. In 2007, FEMA engaged our Regional and National Emergency Response Teams (ERT-N) and the Federal Incident Response Support Teams (FIRST) in two National Exercises: Vigilant Shield and TOPOFF 4. In addition, interagency and intra-agency cross training is accomplished though participation in other venues. For example, the FIRST Teams have:

- Cross trained with the Mobile Emergence Response Support System (MERS);
- Attended and participated in numerous conferences, workshops, and seminars at the Regional, State and local levels; and
- Participated in major state level events with State and local emergency management and public safety officials.

The development of the Incident Management Assistance Teams (IMAT) is well underway. It is estimated that National IMATs as well as the Regional IMATs will be deployed to disaster related responses up to 50 percent of their time. These deployments serve as excellent venues for real life hands on training and skill development. When not deployed, these teams will continuously engage in a rigorous training and exercise program with other emergency management partners at the National, State, and Regional levels.

Policies, procedures, and other task specific guidance are critical. IMAT Position Task Books are being developed for each team position to ensure the individual assigned to their position obtains the requisite education, training, and experience needed to successfully perform their duties. The Emergency Management Institute (EMI) is also providing training guidance and course development in preparation to deliver a multitude of courses that improve our overall readiness and response capabilities.

22. **Both GAO and the DHS Inspector General found that FEMA's use of noncompetitively awarded contracts exposed FEMA to millions of dollars of wasteful, abusive and potentially fraudulent spending and billing practices.**

    a. **What actions has FEMA taken to increase its oversight on existing contracts that were awarded noncompetitively?**

FEMA has taken steps to increase its oversight of existing competitive and non-competitive contracts, through the use of new Contract Administration Plans (CAPs), a new Contracting Officer's Technical Representative (COTR) Program Office, and internal control procedures.

Contract Administration Plans (CAPS)
FEMA has prepared Contract Administration Plans (CAPs) to ensure that its large and complex contracts are effectively administered. CAPs, which are designed to facilitate efficient and effective contract administration, outline the required level of contractor performance surveillance, contract terms and conditions for contract administration, performance milestones, and reporting requirements. FEMA's CAPs improve the Agency's post-award contract execution by providing a consistent guide on ordering, competing, and administering procedures for task orders on task order-type contracts. Use of CAPs promotes task order competition while ensuring that services are available expeditiously to meet critical disaster response needs. In addition, these plans establish consistent enterprise-wide contract administration processes, which allow multiple certified COTRs to use the vehicle consistent with agency business practices.

COTR Program
FEMA has created a COTR Program Office, that provides COTRs the training, support, and tools needed for effective contract administration. The FEMA COTR Program Office was established to provide Agency-wide oversight, accountability and operational effectiveness of FEMA's COTRs by improving the skills and abilities of its COTRs.

The program objectives include:

- Develop a program that will give COTRs the training, support, and tools needed for effective contract administration;
- Implement a tiered COTR certification program to better match COTR competencies to contract complexity;
- Shape the COTR workforce to ensure a higher level of competency and professionalism; and

- Comply with DHS and Office of Management and Budget regulations and policy while leveraging best practices.

The implementation of this program has seen great success in meeting objectives, and accomplishments include the following:

- Creating a shared online COTR community site to efficiently track COTR training and certification documents. It also supports a collaborative resource for all FEMA COTRs, COs and COTR supervisors. For the various audiences, the COTR Community site offers the following:
    - Information and procedures for COTR certification and training
    - Helpful tools and templates for contract administration
    - Forums for asking questions on contract administration
    - DHS certification status
- Issuing an official COTR policy, which has improved overall management of the COTR program
- Conducting comprehensive training for all Gulf Coast-certified COTRs
- Implementing a Contractor Performance System to collect and maintain performance evaluations for all requirements over $100,000.

Internal Control Procedures
FEMA has implemented internal control procedures to enforce the existing invoice payment and review process. FEMA established an office in the Gulf Coast that is responsible for enforcing the standardized invoice payment process. In order to enforce stronger internal controls, the office designed and conducted multiple training events across the Gulf Region outlining and providing guidance on topics such as: "What is a proper invoice?"; "What constitutes proper documentation for receipt of goods and services?"; "How should invoices be reviewed and how can work be confirmed?"; "What justifications for partial payments are required?" In support of the training effort, Standard Receiving Documents and Justification Forms have been designed and are required for invoices that are to be processed.

Additionally, the Office of Acquisition Management has obtained the services of a contractor to review, assess, improve and automate the invoice approval and payment process. This will result in automation of much that currently is a "paper pushing" process open to human error. Automation will provide, among other things, automatic calculation checks and proper line item tracking. It will also produce auditable tracking of each invoice.

b. What actions has FEMA taken to maximize its use of competition when awarding future contracts?

FEMA has learned many lessons from its experiences during Hurricane Katrina and has implemented numerous changes in order to improve its operations. Furthermore, post-Katrina legislation has enabled the Agency to create a vision for a "New FEMA," which better allows FEMA to use competition when awarding contracts. Recent improvements since Katrina that ensure maximum use of competition include the following:

- Pre-Positioned Contracts - Pre-positioned contracts are negotiated and awarded prior to disasters, and ensure the right supplies/services are provided at the right time with a fair and reasonable price. The contracts are for those types of goods and services that are traditionally utilized in a disaster and not currently supported by State and local governments. These pre-positioned contracts ensure competitiveness and price reasonableness, and allow for a more responsive industry focus enabling quick mobilization of resources.

  Some of the major pre-positioned procurements since Hurricane Katrina are:

  - Ambulance Services
  - Rail and Bus Evacuation
  - Housing Inspection Services
  - Individual Assistance Technical Assistance Contracts (IA/TAC)
  - Public Assistance Technical Assistance Contract (PATAC)
  - Web Surge Processing for hosting IT equipment and software which allows disaster victims to register for disaster assistance

- Emergency Acquisition Field Guide - This guide ensures that non-contracting personnel can effectively and appropriately contract for goods and services in an emergency situation. It is specifically designed to define the critical elements of an emergency acquisition in plain language so that any member of the disaster support team can understand and apply proper procedures. The guide includes information on purchase cards, program management, and contracting.

- COTR Training Curriculum - The training program ensures that Contracting Officer Technical Representatives have the requisite skills and competencies to perform required functions. The refresher training includes key acquisition concepts such as Statements of Work, Independent Government Cost Estimates, payment provisions, etc. This training ensures that COTRs are better equipped to effectively manage the Agency's purchased goods and services.

- Disaster Training Course - This course is designed to ensure response contracting professionals are trained on how to award contracts during a disaster, to include compliance with recent legislation. The Agency has required all acquisition personnel at Headquarters and in the Regional offices to complete this course. It was developed by FEMA but was recently adopted by the Federal Acquisition Institute and is now offered throughout the Federal government.

- Contract Administration Plans (CAPs) - CAPs are designed to facilitate efficient and effective administration planning and often outline required level of surveillance, contract terms and conditions for contract administration, performance milestones, and reporting requirements. FEMA's CAPs will improve the Agency's post-award operations, to include providing a consistent guide on ordering, competing, and administering procedures for task orders. They ensure competition of individual task orders for the current Individual Assistance contracts while employing effective contract administration

procedures. In addition, these plans establish an enterprise-wide contract administration process for the COTRs in various locations.

- New Contract Writing System (PRISM) – When implemented, PRISM will provide better workload tracking, more consistent and accurate reporting, and improved contract writing and overall management of its contracts. Furthermore, PRISM is utilized by approximately 60 percent of Federal agencies, allowing for FEMA to more effectively use contracting personnel from other agencies during a major disaster should the need arise.

FEMA has made considerable strides in the number of contract actions it awards competitively. In Fiscal Year 2006, FEMA awarded approximately 54 percent of its contract actions using competitive procedures, ranking last among all DHS components. However, due to the initiatives implemented by the Office of Acquisition Management (OAM), FEMA competitively awarded approximately 70 percent of its contract actions in Fiscal Year 2007, ranking second among all DHS contracting components.

23. **What role would you like to see unions play at FEMA, and what style or arrangements involving labor and management do you intend to foster? For example, will you foster labor-management partnership at FEMA or do you believe that other kinds of arrangements would be preferable? What steps would you take to achieve the kind of labor-management relationships you want?**

Although I come with little experience at interacting with unions, I have come to appreciate the benefits that open and constructive labor-management relationships can bring. The tone for those relationships has been set by Administrator Paulison, who is always accessible to union representatives, attends or participates in every Labor Management Partnership Council meeting, has been innovative in providing union participation in the selection process for senior leaders, and likely has the best union relationships that FEMA has experienced in years.

I have followed the Administrator's lead and have also attended or participated in every Labor Management Partnership Council meeting during my tenure. During these sessions, I have briefed them on our major initiatives, spoken candidly of our challenges, listened and incorporated some of their ideas, and provided opportunities for them to engage with other senior leaders. These actions have afforded them an opportunity to participate in our decision-making process. I believe that I have developed credibility with the union leadership as we have collaborated on actions needed to strengthen FEMA and make the successful transition to the New FEMA. If confirmed, I will continue this course of interaction and foster the continuation of a constructive and beneficial relationship.

Preparedness

24. **The Homeland Security and Governmental Affairs Committee's report, "Hurricane Katrina: A Nation Still Unprepared" found that FEMA does not currently have the resources needed to accomplish its mission and that these resource shortages contributed to FEMA's failures in responding to Katrina. The investigation found that FEMA was especially short of the resources necessary to be prepared for a catastrophe and that there has not been sufficient investment in capabilities to be able to respond to a disaster. The Administration's FY 2007 and 2008 budget requests for FEMA contained increases. What is your vision of the need for increased funding for FEMA for future years?**

Administrator Paulison has embarked on a multi-year strategy to transform the Agency into a revitalized and more sharply focused New FEMA that the Nation observed responding to tornadoes, floods and most recently the California wildfires. We have been aggressive in the use of our existing resources and appreciate very much Congressional support during Fiscal Year 2006 with supplemental funding, in Fiscal Year 2007 with approval of FEMA's reprogramming request, and ask for support in obtaining the full President's request in Fiscal Year 2008. These resources are providing more permanent staff, strengthening of FEMA Regions, needed capabilities (i.e. Incident Management Assistance Teams), and improvements in information management, business processes, operational planning, logistics, communications and other areas of core competency. As FEMA welcomes the expanded mission scope represented by PKEMRA, with its higher level of expectations in regard to all-hazards preparedness, more effective use of grants resources and national leadership in emergency management, FEMA will need to have continued support to gain the full measure of the President's request for continued funding.

In Fiscal Year 2008 and beyond FEMA is pursuing the resources needed to support and strengthen the core mission activities and expand FEMA's ability to 'lean forward' in preparedness, readiness, response and recovery to all disasters. The additional resources request in the Fiscal Year 2008 President's Budget will support the initial phase of the Vision for New FEMA which will enhance core-capabilities, strengthen the Regions, build partnerships with the states, and professionalize emergency management. In addition, resources will support the development of stronger business processes and systems to ensure that FEMA's emergency preparedness and response programs can focus on their core missions rather than administrative tasks and challenges. Our goal is to build on these core competencies and modernize and integrate FEMA IT Systems, invigorate FEMA Logistics, increase permanent positions across FEMA to fill capacity gaps, continuing to integrate and enhance preparedness capabilities and restructure the disaster workforce.

25. **The Post-Katrina Act reformed and strengthened FEMA, providing it with a role and stature well beyond that which it previously had, making it the preeminent federal agency with responsibility for the entire cycle of emergency management. The Administrator of this newly reinvented agency also has significantly enhanced authorities than those of the Director of the old FEMA, including responsibility for national preparedness and state and local grants programs; a higher rank in the federal hierarchy; a direct reporting relationship to the Secretary; and a position as principal advisor to the President on emergency management matters.**

    a. **How are these new authorities improving your, and FEMA's, ability to effectively prepare for and respond to disasters?**

The broadened authorities for FEMA and its Regional offices are providing FEMA with an unprecedented opportunity to better organize and coordinate all aspects of the Nation's emergency management systems across the Federal government, with the states and their major urban areas, and with non-governmental organizations and the private sector. The integration of preparedness functions with the response, recovery and mitigation functions of FEMA involve both programmatic and administrative integration efforts in the areas of strategic policy, grants, planning, training, and exercises, to name a few. We are already seeing a benefit as operational assessments are being reflected in the preparation of Fiscal Year 2008 grant guidance, and we are finding synergies in planning, training and the conduct of exercises.

The Administrator has a direct and productive relationship with the Secretary and the President, which has been evidenced by the response and coordination to Hurricane Dean and the Wildfires in California. FEMA is positioned via the National Preparedness Directorate (NPD) to lead in the design and implementation of the National Preparedness System. The System will include development of preparedness policy, doctrine, oversight of program implementation by the Regions, and analysis of outcomes for all hazards preparedness across the Nation. This includes the Federal agencies, State, local, private sector, and non-governmental organization preparedness. In addition, the NPD National Integration Center combines new and existing FEMA training institutions and programs and will help apply a common standard to the design, development, and delivery of the full scope of training and exercise activities.

For the first time, DHS has a dedicated grants management organization – FEMA's Grant Programs Directorate (GPD) – that will apply a common administration framework for both disaster and non-disaster grant programs. GPD's critical mission will be to assist grantees in employing risk management frameworks to achieve homeland security capability targets, while also providing a unified approach to Federal financial assistance management in support of FEMA's multi-faceted mission and customer base.

Also for the first time, the Department will have an established regional structure for delivering preparedness assistance and interacting with State, tribal, territorial, and local government, private sector, and community stakeholders. The co-location of preparedness assets and programs at the ten FEMA Regions is a key element in our efforts to integrate new and existing preparedness programs at FEMA. Their co-location at the Regions will not only ensure a close

working relationship with an expanded scope of stakeholders, but also ensure that homeland security preparedness efforts are closely linked with response and recovery operations.

With the new authorities, and the initiatives as described, all of FEMA leadership, from the Administrator and Headquarters leaders to the Regional Administrator, have a larger stage and greater stage presence to lead, advocate and influence the development of a stronger preparedness culture and emergency management infrastructure.

b. Of FEMA's new authorities, which is proving to be most important in increasing FEMA's, ability to improve preparedness and response?

With the incorporation of the full Preparedness mission into FEMA, this new authority has allowed FEMA to leverage the expertise of preparedness planning with our response operations. This marriage of theoretical work with the practical operational planning resulted in a very successful Gap Analysis planning effort with the 18 hurricane prone states and territories this past summer. Through lessons learned in this planning effort our preparedness and operations staffs now are developing a broader planning process for the next calendar year that can be utilized nation-wide. Also as a result of these new preparedness authorities, we are able to better align and integrate the grants, planning, training and exercise opportunities with the State and local governments.

c. Are there additional authorities that you believe FEMA still needs?

FEMA continues to evaluate and review its authorities and will communicate those with the Congress following a thorough discussion with the Department and the Administration.

26. **The Post-Katrina Act requires that FEMA develop and coordinate the implementation of a risk-based, all-hazards strategy for preparedness. What are FEMA's plans to implement this provision?**

The Post-Katrina Act comprehensively defined the components of a risk-based, all-hazards strategy for preparedness, noting the central importance of building capabilities necessary to respond to natural disasters, acts of terrorism, and other man-made disasters. The Department published the National Preparedness Guidelines and Target Capabilities List in September 2007. The Guidelines replaced the Interim National Preparedness Goal published in March 2005. Development of a strategic approach to national preparedness was first established in 2003 with the publication of Homeland Security Presidential Directive 8, "National Preparedness." DHS has worked since then with over 100 national associations and hundreds of Federal, State, local, tribal and private sector stakeholders to craft a pragmatic strategic approach to national preparedness. PKEMRA directed the consolidation of national preparedness programs, activities and services within FEMA, and is guiding our approach to preparing the Nation.

The Guidelines encompass the strategic spectrum of prevention, protection, response, and recovery efforts to prepare the Nation for all-hazards and outline a series of national preparedness priorities necessary to achieve the Nation's strategic preparedness objectives.

They include four critical elements: a national preparedness vision, a set of National Planning Scenarios, a comprehensive task list, and a catalog of 37 specific target capabilities necessary to building effective all-hazards preparedness. The vision clearly states our strategic task to create "A Nation Prepared" with coordinated capabilities to prevent, protect against, respond to, and recover from all hazards in a way that balances risk with resources and need."

This vision is guiding the preparedness programs, services, and activities we provide through both our National Preparedness and Grants Program Directorates, including the core homeland security and infrastructure protection grant programs. The Guidelines ensure strategic unity of effort and support the National Strategy for Homeland Security by developing an interconnected and complementary national preparedness system, sustaining efforts over the long term, and increasing preparedness collaboration, coordination, and cohesion on a scale never before seen in the United States.

27. **FEMA now has the primary responsibility for Mass Care.**

   a. **What has FEMA done to build the capabilities necessary to lead Mass Care aspects of the response?**

Mass Care is now an integral component of FEMA's response structure in the National Response Coordination Center (NRCC) and field operations – staffed with American Red Cross (ARC) and FEMA experts in sheltering, feeding, commodities distribution, and evacuations planning. FEMA accomplished this by establishing a Mass Care section at the national level. At the Regional level, ARC has embedded an ESF #6 Mass Care Planner in each of FEMA's ten Regional offices.

FEMA has regular coordination program and logistics coordination meetings with ARC to ensure the coordinated acquisition and distribution of commodities. Together, FEMA and ARC are managing a National Shelter System that tracks shelters and occupants nationwide, in partnership with State and local governments. The Agency's expanded capabilities successfully demonstrated on the California wildfires through:

- The assembly and deployment of a Tiger Team, tasked with evaluating the ongoing need for temporary housing and delivery of Mass Care services. Teams included representatives from FEMA, ARC, and USACE.
- Successful launch of the National Emergency Family Registry Locator System and the National Emergency Child Locator Center. Both services are designed to facilitate family reunification following a disaster.

In addition, FEMA is pursuing the following initiatives:

- Developing case management pilot project together with the Department of Health and Human Services (HHS).
- Developing protocols for efficiently transitioning evacuees from congregate shelters to other transitional housing if they must remain in a host location for longer than 30 days.

- Developing detailed plans together with Federal, State and NGO partners to ensure that evacuees are tracked from embarkation to shelter when mass evacuations occur.
- Developing detailed plans together with Federal, State and NGO (including HHS partners) to support pet evacuation and sheltering in the event of a mass evacuation.
- Identifying pre-scripted scopes of work for Federal agency, contract, and NGO support to ESF #6 Mission, including shelter management, specialized needs, feeding, housing, and transport.
- Finalizing a National Disaster Housing Strategy that outlines the roles, responsibilities, and coordination mechanisms of Federal and State partners in the identification and delivery of disaster housing resources.

b. When do you expect that FEMA's capabilities will be adequate to lead the Mass Care effort in a catastrophe?

FEMA is positioned, postured, and prepared to lead the Federal mass care effort in a catastrophe. Nonetheless, we continue to seek ways to improve our coordination and planning with our important mass care delivery partners, such as the ARC, other voluntary agencies, FEMA Logistics, USDA, DOD, etc. FEMA is focusing on developing enhanced evacuation, sheltering, and housing systems that will include national planning, standards, credentialing, typing, common terminology, and standards of performance. While these systems will take years to fully mature, we are more prepared than ever before to lead and coordinate the delivery of the mass care services under ESF #6. We continue to invest in training staff and our partner agencies.

28. **FEMA's job as coordinator of the National Response Plan (NRP) includes ensuring that other agencies with NRP responsibilities are prepared to respond to a catastrophe, either natural or manmade.**

a. What is FEMA's current understanding of whether other federal agencies have the resources and capabilities needed to fulfill their obligations under the National Response Plan?

FEMA is in constant communication with our Federal partners to ensure that the roles and responsibilities of the interagency community in support of Emergency Support Functions (ESF) are clear. As part of our current Gap Analysis Program, we include the interagency community in identifying capabilities to support vulnerabilities identified in the hurricane prone states along the Atlantic and Gulf Coasts in the critical areas of sheltering, evacuation, debris removal, commodity distribution, medical needs and fuel availability. The Gap Analysis Program will expand to all FEMA Regions during Fiscal Year 2008. We work directly with the agencies supporting the ESFs to build their individual annexes to the NRF to capture each agency's specific commitment in response to a major disaster.

The NRF is organized around the performance of the ESFs which include key tasks and activities that are central to emergency operations. For each of these functions, one Federal agency is assigned primary responsibility, with others designated as providing support to that agency. The ESF structure provides the means to integrate and transition between pre-incident preparedness

and response activities. Homeland Security Presidential Directive-8, entitled "National Preparedness," requires Federal departments and agencies to maintain "specialized Federal assets such as teams, stockpiles, and caches...at levels consistent with the National Preparedness Goal (now Guidelines) and be available for response activities as set forth in the National Response Plan (now Framework), other appropriate operational documents, and applicable authorities or guidance."

FEMA participates in continual coordination through such structures and the Domestic Readiness Group and the ESF Leaders Group to monitor ESF preparedness. FEMA administers the National Exercise Program, which provides the means to periodically exercise the integrated Federal response. FEMA recently administered the fourth Top Officials (TOPOFF) national exercise which provides the most rigorous test of capability availability and employment. PKEMRA requires an annual report on Federal preparedness to document resource status and overall readiness. FEMA is finalizing the first report, and is field-testing a comprehensive assessment system to support the collection and reporting of Federal, State and local preparedness, capability posture, and resource needs as required by PKEMRA.

b. If confirmed, what steps will you take to ensure that FEMA adequately fulfills its responsibilities of ensuring that other federal agencies are prepared to respond to a catastrophe?

I will ensure that FEMA continues to work closely with its Federal counterparts through existing coordinating structures such as the Domestic Readiness Group and the ESF Leaders Group, and the Regional Interagency Steering Committees to continually monitor ESF preparedness. I will ensure implementation of the provisions of PKEMRA that provide a framework for comprehensive assessment of Federal agency readiness, including administering the National Exercise Program to periodically exercise the integrated Federal response. FEMA is field-testing a comprehensive assessment system to support the collection and reporting of Federal, State and local preparedness, capability posture, and resource needs as required by PKEMRA. Following this field-test, I will review the results with our new National Preparedness Directorate to determine if it meets PKEMRA requirements and can be implemented, within available resources, to support the assessment and reporting requirements established by PKEMRA and Homeland Security Presidential Directive-8 (National Preparedness).

Additionally, FEMA is coordinating inside DHS and across Federal departments and agencies to develop a national planning system. This system will lead to a series of strategic and operational plans that will align authorities, clarify roles and responsibilities, define requirements, assess capabilities and provide visibility of gaps in any of these areas. FEMA also continues to work with other departments and agencies to refine the mission assignment process and develop pre-scripted mission assignments so that any all-hazards response will have more ready access to the broad array of Federal response and recovery capabilities.

Finally, FEMA has initiated a Catastrophic Disaster Response Planning Initiative to improve response capabilities that complement the NRF, NIMS, and State and local planning activities.

FEMA's Disaster Operations Directorate has collaborated closely with other Federal agencies to ensure continued visibility with Federal, State, local, tribal, and private sector partners in activities related to responding to catastrophic disasters. FEMA catastrophic disaster response planning initiatives are currently focused on four specific geographic areas: Southeast Louisiana, the eight states in the New Madrid Seismic Zone (NMSZ), the State of Florida, and the State of California. By nature of its geographic-specific and hazard-specific design, the Catastrophic Disaster Response Planning Initiative provides yet another opportunity for FEMA to engage directly with its partners to examine in detail existing catastrophic disaster response capabilities, including those of our Federal partners, and to identify areas needing improvement.

In a collective manner, these initiatives demonstrate FEMA's focus on planning and assuring the Federal capabilities are known and programmed to meet any eventuality across the all-hazards spectrum. Our purpose is to ensure not only that these capabilities are known, but that they can be activated and are available where and when needed.

Evacuation

29. **What is your vision of the proper role of the federal government in assisting state and local officials with evacuation? What, if any, role did FEMA play in the evacuation effort due to the wildfires that burned in California in October 2007?**

State and local officials have the primary responsibility for public safety and emergency services, with the Federal government providing resources, guidance and assistance to supplement State and local government capabilities and to aid in developing the capacity and proper planning for mass evacuation. FEMA engaged with each of the States to assist in their evacuation planning by providing technical assistance. This was most evident during preparations for the 2007 hurricane season by application of the Gap Analysis Program. FEMA has engaged the Gulf States specifically to coordinate the preparation of a Gulf Coast Mass Evacuation Plan.

FEMA recently published the National Preparedness Guidelines, including a series of national preparedness priorities that prioritize mass evacuation planning. The Guidelines were accompanied by a Target Capability List that includes a specific target capability entitled "Citizen Evacuation and Shelter-In-Place," which comprehensively describes the elements and critical tasks that comprise an adequate evacuation and shelter-in-place capability. FEMA administers the homeland security grant programs, which provide targeted funding to enable State and local officials to build core capabilities such as mass evacuation. Congress provided targeted funding in Fiscal Year 2007 for urban areas designated as "Tier 1" in the Urban Area Security Initiative (UASI) grant program. FEMA will be making these awards shortly, and the program includes emphasis on mass evacuation and sheltering, with particular emphasis on special needs/special medical needs populations.

In California, over 300,000 individuals were impacted by the wildfires that began burning on October 21, 2007. Mandatory and voluntary evacuation orders were in effect for seven counties which resulted in the opening of state-run and American Red Cross shelters within hours of the events. The majority of individuals self-evacuated to either hotels, motels or to

family or friends' houses. The remainder moved temporarily to shelters – with peak shelter activity occurring in the first 72 hours with about 22,000 individuals in over 50 shelters, the largest being Qualcomm Stadium in San Diego. FEMA played a very small role in the evacuations but provided blankets, cots and other supplies needed by the State.

30. **What steps has FEMA taken to catalogue available federal resources at the Department of Transportation and other agencies that it could dispatch when state and locals are overwhelmed with evacuation needs?**

The draft National Response Framework includes a Mass Evacuation Annex that defines the roles and responsibilities of Federal agencies in support of a mass evacuation. In support of this annex, FEMA Disaster Operations is currently developing a Mass Evacuation Supplement that will define, at a tactical level, tasks that must be performed at each step of a mass evacuation.

The bulk of the Federal support to an evacuation in the form of transportation and commodity support will come from FEMA Logistics vis-à-vis a Pre-Scripted Mission Assignment (PSMA) to the Department of Transportation (DOT) as well as other departments and agencies. This past year, FEMA and DOT entered into a memorandum of agreement that transferred many of the traditional DOT transportation support capabilities to FEMA. As a result, FEMA currently administers bus and ambulance (includes paratransit vehicles) contracts to assist during an evacuation effort that exceeds a State's capabilities. FEMA also has a separate contract with Amtrak to support possible Gulf Coast evacuation needs. FEMA also coordinates with the Department of Defense through a DOT memorandum of agreement to access commercial air support when needed to support disaster related evacuation. Under National Disaster Medical System (NDMS) activation, the Department of Defense will support DHS with Strategic Patient Movement and Airlift, as appropriate. We have also coordinated with Air Mobility Command to support commercial air transportation needs for potential Gulf Coast evacuation efforts.

FEMA has embarked on an Evacuee Support Planning Project that will address the all-hazards mission of FEMA's Disaster Assistance Directorate in support of displaced disaster victims. The Evacuee Support Planning initiative focuses on developing strategies and guidelines for support of mass evacuations and displaced disaster victims through development of planning guidance and a Host-State Evacuee Support Plan template. To ensure the guidance and template realistically address State concerns and operational perspectives, the template will be created and refined from host-state evacuee support plans developed in select states. The host-state evacuee support plans are developed through workshops that employ realistic catastrophic scenarios and consequence estimates which drive discussion and planning, and ultimately the creation of functional, integrated evacuee support plans.

31. **Sheltering is an important component for a successful evacuation as without a place to go, it is much harder to convince individuals to evacuate. What steps has FEMA taken to integrate planning for sheltering with planning for evacuation at a national level?**

FEMA published the National Preparedness Guidelines in September 2007, which include a series of national preparedness priorities for mass evacuation planning and sheltering. The Guidelines were accompanied by a Target Capability List that includes a specific target capability entitled "Citizen Evacuation and Shelter-In-Place," which describes in detail the elements and critical tasks that comprise an adequate evacuation and shelter-in-place capability. Each capability includes specific critical tasks, as well as preparedness and performance measures to enable measurement of capability proficiency and sufficiency.

FEMA recently completed a comprehensive mass evacuation and shelter planning effort with the states of Louisiana, Mississippi and Alabama and neighboring states in preparation for the 2007 hurricane season. During this process, FEMA assisted the State of Louisiana to expand their shelter inventory and ensure a maximum capacity to shelter as many evacuees in-state as possible. FEMA also identified shelter capacity in each of the adjoining states: Mississippi, Alabama, Georgia, Arkansas, Tennessee, and Texas. This Gulf Coast plan combined multi-modal transportation assets (i.e. bus, train, air) with specific destination sites and pre-identified shelter locations.

FEMA is developing a comprehensive Gap Analysis Program designed to support States with a comprehensive evaluation of both evacuation and sheltering needs. The goal of the Program is to provide surveys, tools and plans for estimating needs, capabilities, and resource shortfalls. Congress provided targeted funding in Fiscal Year 2007 for urban areas designated as "Tier 1" in the Urban Area Security Initiative (UASI) grant program. FEMA will be making these awards shortly, and the program includes emphasis on mass evacuation and sheltering, with particular emphasis on special needs/special medical needs populations.

32. **In the event that a catastrophic hurricane threatens New Orleans, Louisiana or any other coastal state, what are FEMA's plans with respect to providing direct federal assistance with the pre-storm evacuation and safe shelter of residents who lack personal transportation, who live in mobile homes or travel trailers provided by FEMA, or for those who are admitted to a hospital or qualify as a special needs patient?**

FEMA recently completed a comprehensive mass evacuation and shelter planning effort with the states of Louisiana, Mississippi, Alabama, Texas, Georgia, Kentucky, Tennessee, Arkansas and Oklahoma to define specific plans, evacuation routes, transportation modes, and resource requirements to enable synchronized multi-state evacuation in preparation for the 2007 hurricane season. This included evacuation and sheltering capacity, requirements and shortfalls for the general population, transportation dependent populations, special medical needs populations, and pets. This effort included workshops and exercises with participation by both risk and host states, FEMA Regions, FEMA headquarters, private sector transportation providers, non-governmental entities, and other Federal departments and agencies with responsibilities for providing assistance through the National Response Plan.

The lessons of this effort contributed to specific preparations for the current and future hurricane seasons, and to ongoing development of a comprehensive "Gap Analysis" program designed to support states with a comprehensive evaluation of both evacuation and sheltering needs. The

goal of the Program is to provide surveys, tools and plans for estimating needs, capabilities, and resource shortfalls across eight critical operational functions, including evacuation and sheltering. This effort included exercises and workshops that included participation by the states, two FEMA Regions, FEMA headquarters, private sector partners, and other Federal departments and agencies with a role in supporting mass evacuation and sheltering.

FEMA is also conducting dedicated catastrophic disaster planning activities in coordination with the State of Florida for a Category 5 Hurricane impacting southeastern Florida. This two phased project has a specific focus on evacuation planning in the adjacent counties around Lake Okeechobee, and requirements associated with responding to a Category 5 Hurricane impacting South Florida and Miami.

33. **Please describe the current status of FEMA's implementation of sections of the Post-Katrina Act related to evacuation plans and exercises codified at 6 U.S.C. Section 321a.**

FEMA administers the homeland security and emergency management grant programs on behalf of the Department of Homeland Security. These grants provide funding that enables the development and maintenance of mass evacuation and sheltering plans and preparation for their execution. The National Exercise Program and Homeland Security Exercise and Evaluation Program provide the means to conduct exercises of mass evacuation and sheltering plans. In September of 2007, FEMA published the Target Capability List, which includes a specific capability for "Citizen Evacuation and Shelter-In-Place." The target capabilities comply with direction in PKEMRA to establish target capabilities and achieve levels appropriate to all-hazards. FEMA provides technical assistance to State and local governments to assist in evacuation and shelter planning. FEMA has recently updated its State and Local All-Hazards Planning Guide (SLG 101) as Comprehensive Preparedness Guide (CPG) 101, "Producing Emergency Plans: A Guide for All-Hazard Emergency Operations Planning for State, Local, and Tribal Governments." The draft guide includes significantly improved planning guidance for evacuation and shelter-in-place, and complements the September 2007 National Preparedness Guidelines and Target Capability List. The draft CPG is currently under review by Federal, State and local subject matter experts.

Emergency Housing

34. **In the aftermath of Hurricane Katrina, the trailers used by FEMA to house disaster victims were widely criticized. In response to the criticism, section 408 of the Post-Katrina Act gave FEMA new authority to give it more flexibility in the types of housing assistance it could provide to disaster victims, allowing it to, in addition to providing temporary housing assistance, provide semi-permanent and permanent housing assistance.**

    a. **How does FEMA plan to use this additional authority?**

FEMA will exercise its authority to provide financial and direct permanent and semi-permanent housing construction assistance, on a disaster-specific basis, where there are no alternative housing resources available and other forms of temporary housing are unavailable, infeasible, or not cost-effective. This new authority has been factored into the National Disaster Housing Strategy and is part of our Housing Task Force list of alternatives. FEMA will evaluate each event for the most appropriate housing solution.

b. What alternatives to the trailer and mobile home program has FEMA considered?

As part of the National Disaster Housing Strategy, FEMA has been evaluating alternatives to travel trailers and mobile homes through its multi-agency Joint Housing Solutions Group. The Joint Housing Solutions Group has developed housing evaluation criteria, a Housing Assessment Tool, and screened, tested and rated more than 100 alternative housing providers and their products ranging from panelized, manufactured, and modular homes to shipping container prototypes. The Alternative Housing Pilot Program, a competitive grant program designed to test innovative disaster housing while providing Katrina and Rita victims with safer and more comfortable options to travel trailers and mobile homes, complements the work being done by the Joint Housing Solutions Group. This $400 million four--year program consists of five projects in Alabama, Mississippi, Louisiana, and Texas. FEMA manages the project, and has asked the Department of Housing and Urban Development to evaluate each project for its suitability for future disaster operations. The next step is to begin piloting select housing units to gauge field performance, an effort we intend to pursue as disaster opportunities arise in calendar year 2008.

Regional Offices

35. **The Post-Katrina Act formally established the ten FEMA regional offices and gave significant new responsibilities to the Regional Administrators. For example, they must have regional capabilities for a national catastrophic response system; develop regional plans that support the NRP, and maintain and operate a regional response coordination center. What initiatives do you plan to implement to ensure that regional offices meet their national preparedness responsibilities?**

The Region is the essential field echelon of FEMA that engages most directly with State partners and disaster victims to deliver frontline services. It is the Region that can build and nurture State and local capabilities across the spectrum of preparedness, response, recovery and mitigation. And it is the Region that will lead the Federal response to incidents across the spectrum of all-hazards events. A strong FEMA will rely on strong Regions to regain the trust and confidence of Governors, mayors, leaders in the private sector and the citizens of our homeland. Significant increases in field personnel will be planned out in future years to include regional staffing enhancements in: Disaster Operations, Emergency Communications, Disaster Assistance, Preparedness, Grants Management, Logistics and Mitigation. These additional resources will support implementation of new functions such as regional Incident Management Assistance Teams, full 24/7 operational capability of the Regional Response Coordination Centers to ensure

full situational awareness, and build robust field operational planning, logistics and communications capabilities.

National Preparedness Integration and Coordination

National Preparedness Integration Program (NPIP). Through the NPIP, FEMA will integrate and synchronize strategic tools, including the National Incident Management System, National Response Plan, National Infrastructure Protection Plan and the National Preparedness Goal into a national operational capability. The NPIP will ensure development of preparedness processes that foster harmonized day-to-day routine interaction of disciplines, organizations, levels of government and our citizens. NPIP's capability requires partnerships at the headquarters level, among those in the field and on the front line.

National Capital Region Coordination (NCRC). NCRC leverages local, State, Regional, and Federal partnerships to execute the strategic priorities of FEMA and the National Capital Region. NCRC coordinates directly with State and local government partners, as well as FEMA Region III and other Federal agencies in the NCR to integrate regional homeland security and emergency preparedness programs. As such, NCRC will continue to coordinate ongoing initiatives with these partners, including multi-jurisdictional data and communications interoperability, evacuation and catastrophic planning coordination, electronic emergency response credential validation, bio-detection notification, Federal protective measures procedures and protocols, operations coordination, and regional all hazards risk assessment to enable informed resource allocation and strategic capability development.

Federal Preparedness Coordinators (FPCs). As the Nation's Preeminent Emergency Management Agency, we will establish a network of regional Federal Preparedness Coordinators to integrate and synchronize preparedness across jurisdictions and all levels of governments. Strengthening preparedness requires a dedicated, regionally-based DHS senior executive to support the networks of Federal, State, local, tribal, and private-sector partners to plan, train and exercise in preparation for coordinated contingency missions, as well as to share information on a routine basis. They will establish a Regional domestic all-hazards preparedness goal, integrating mechanisms for improved delivery of Federal preparedness assistance to State and local governments and outlining actions to strengthen preparedness capabilities. Their preparedness goal will include measurable readiness priorities and targets that appropriately balance the potential threat and magnitude of terrorist attacks, major disasters, and other emergencies with the resources required to prevent, respond to, and recover from them.

Evaluation and National Assessment Program. FEMA will gather, analyze and interpret National and program specific data. As the focal point for information collection and evaluation, this program reviews and assesses the execution of State strategies against the supporting threat, vulnerability, and needs assessment data. As data is evaluated, meaningful and timely feedback highlighting best practices can be identified for replication, and knowledge gaps can be addressed and mitigated. This information will then be fed back out to States and jurisdictions by the National Preparedness Directorate.

Radiological Emergency Preparedness Program (REPP). We will assist State, local, and tribal governments in the development of offsite radiological emergency preparedness plans within the

emergency planning zones of Nuclear Regulatory Commission (NRC) licensees of commercial nuclear power facilities. REPP will continue to support the development of offsite radiological emergency preparedness plans for the emergency planning zones of NRC licensees of commercial nuclear power facilities.

Chemical Stockpile Emergency Preparedness Program (CSEPP). Through CSEPP, we will enhance existing local, tribal, and State capabilities to protect the health and safety of the public, workforce, and the environment from the effects of a chemical accident or incident involving the eight United States Army chemical stockpile sites.

Grants, Training, and Exercises

FEMA will serve the public by equipping American first responders – firefighters, police officers, and emergency medical providers. Multiple Grants and Training programs provide agencies with grant resources to acquire equipment, training, or technical assistance to prepare them to prevent, deter, and respond to terrorist acts and natural disasters.

State Preparedness Grants Program. FEMA will administer three grant programs that will provide a baseline level of security to State, local and territorial level jurisdictions:

- The *State Homeland Security Grant Program*, which awards grants to all 50 States, the District of Columbia, Puerto Rico and four U.S. Territories, based on risk and need;
- *Citizen Corps*, a grass-roots initiative that actively involving all citizens in hometown security through personal preparedness, training, and volunteer service; and
- The *Emergency Management Preparedness Grant (EMPG)* Program, which provides funds to support comprehensive emergency management at the State and local levels and encourages the improvement of mitigation, preparedness, response, and recovery capabilities for all hazards.

National Exercise Program. We will test State and local capacity to effectively implement best practices and deploy response plans and assets efficiently and effectively, and support the Department's Federal, State and local exercise programs, which includes the Top Officials (TOPOFF) exercise series.

Urban Area Security Initiative (UASI) Regional Grant Program. FEMA will award grants based on the evaluation of both risk and need, and provide a second layer of security to the Nation's high risk urban areas, and strengthening the Nation's urban areas and critical infrastructure.

State and Local Training Program. We will develop and approve training to prepare emergency responders for a Weapons of Mass Destruction (WMD) terrorism event. We will identify the training needs of State and local communities and prioritize those needs in order to facilitate the identification of existing and new funding for course development. This program includes the Center for Domestic Preparedness, the only WMD training facility that provides hands-on training to civilian emergency responders in a toxic chemical agent environment, and the

National Domestic Preparedness Consortium, which also plays a major role in delivering training to America's first responders.

Technical Assistance Program. Through direct assistance to State and local jurisdictions, FEMA will help improve their ability to prevent, respond to, and recover from threats or acts of WMD terrorism. Specifically, the Technical Assistance Program will work to enhance the capacity of State and local jurisdictions, including special needs jurisdictions like port authorities and mass transit agencies, to develop, plan, and implement effective strategies for WMD preparedness.

State and Regional Grant Advocates

FEMA will establish Grant Advocates in the Regions. The Grant Advocates will:

- *Provide Technical Assistance Closer to the Client.* The Region is the essential field echelon of FEMA that engages most directly with State partners for all FEMA services to include grants and guidance technical assistance. It is through the Region that we can build and nurture State and local capabilities across the spectrum of preparedness, response, recovery and mitigation utilizing the preparedness grant programs. The Regional Grant Advocates will be assigned responsibility for specific States for direct day-to-day interaction and support to the States on grant issues.
- *Strengthen our partnership with States and UASI Urban Areas.* Grant advocates will be assigned for each State within the Region to assist the State Administering Authority (SAA) in developing, executing and monitoring their grants for preparedness activities. The advocates will assist in providing guidance documents, develop relationships to further refine grant expenditures to meet unfunded requirements, and provide assistance to the Federal Preparedness Coordinators in quantifying capability gaps based on the Target Capabilities List and the National Preparedness Goal.
- *Provide Greater Grant Accountability.* The State and Regional Grant Advocates will also work with the States to develop metrics to track the use of the preparedness grant dollars to help ensure that those funds are being used to meet the gaps identified by the State and local jurisdictions as validated by Preparedness.

Fire and Emergency Assistance

FEMA will work with firefighters and emergency responders to improve their capability and effectiveness.

United States Fire Administration (USFA). We will continue to reduce life and economic losses due to fire and related emergencies, through leadership, coordination, and support. Through the USFA, FEMA will prepare the Nation's first responder and emergency response managers and leaders through ongoing and, when necessary, expedited training on how to evaluate and minimize community risk, improve protection to critical infrastructure, and become better prepared to respond to all hazard and terrorism emergencies of all kinds.

Assistance to Firefighter Grants (AFG). Through the Grants Programs Directorate, FEMA will support the Nation's firefighters by awarding one-year grants directly to fire departments in order to enhance the effectiveness of firefighting operations throughout the United States.

Strengthen FEMA's Incident Management Capability

Ensure 24/7 operational awareness. FEMA will improve around the clock operational awareness by establishing 24/7 operations in the National Response Coordination Center (NRCC) at headquarters and the Agency's ten Regional Response Coordination Centers (RRCCs), and help enable the Agency to shift its footing from a reactive to a ready stance, able to act swiftly and decisively in both notice and no-notice all-hazard events to activate and coordinate Federal response actions.

36. **How many operational planners does FEMA intend to hire? How many will work in the regional offices, and how many at FEMA headquarters? When do you hope to have these positions filled?**

FEMA intends to hire a total of 83 operational planners. Of these, 17 will work at FEMA Headquarters, 60 will work in FEMA Regional offices, and 6 will work in FEMA Area offices. All of these positions are intended to be filled by Fiscal Year 2009, as follows:

	FEMA HQ	**Regions**	**Area Offices**	**TOTAL Positions**
FY 2007	15	10	3 (1 per office)	**28**
FY 2008	-	30 (3 per Region)	-	**30**
FY 2009	2	20 (2 per Region)	3 (1 per office)	**25**
	17	**60**	**6**	**83**

In addition, FEMA intends to hire a total of 45 Planning Positions for the ten Regional and three National IMATS.

- Each of the ten Regional IMATs will have three Planning Positions (Planning Section Chief, Situation Unit Leader and Resource Unit Leader)
- The three National IMATS will have five Planning Positions (Planning Section Chief, Situation Unit Leader, Resource Unit Leader, Documentation Unit Leader, Geospatial Intelligence Unit Leader).

The goal is to hire four Regional teams (twelve positions) and two National Teams (ten positions) in Fiscal Year 2008 and the remaining six Regional and one National Teams in future years.

Emergency Response Teams

37. **The Committee's investigation of Hurricane Katrina found that one of the serious problems contributing to the failed federal response was FEMA's failure to have enough emergency response teams and the failure to have enough trained and exercised personnel and equipment for those teams that existed. The Post-Katrina Act sought to fix this serious deficiency by requiring DHS to maintain an emergency response team called a "strike team" in each FEMA region. FEMA has recently admitted that not all of these strike teams had been created, as required by the legislation. According to recently submitted responses to post-hearing questions from FEMA Administrator Paulison, FEMA's current plan is to have one permanent national strike team, which FEMA has decided to call a National Incident Management Assist Team (IMAT), and three permanent Regional IMAT's in place by September 30, 2007.**

    a. **Does FEMA now actually have one permanent National IMAT Team, and three Regional IMAT's? Please name the positions on each of the existing teams.**

FEMA is currently hiring individuals to serve on the three Regional and one National IMATs with a goal to have the majority of personnel hired for these first four teams by December 31, 2007.

Progress to date:

- Applicants for 13 of the 15 positions for the Region IV have been selected;
- Applicants for 9 of the 15 positions for Regions V and VI have been selected; and
- Applicants for 13 of the 26 positions on the National IMAT have been selected for interviews. The interview process, however, was temporarily interrupted when the hiring panel and many of the subject matter experts where deployed to the Southern California wildfires.

    b. **When will FEMA have all of the strike teams in place that are required by the legislation? Has FEMA budgeted enough to support all of the required strike teams? If not, why not? What is FEMA's budget estimate for each team?**

FEMA has a phased plan for hiring all three National and ten Regional Teams. It is FEMA's goal to have all teams in place by the end of Fiscal Year 2009. In addition to the first four teams (one National and three Regional teams) which are currently being established, FEMA intends to stand up one additional National and one additional Regional Team in Fiscal Year 2008. FEMA is currently finalizing a spend plan for these teams and identifying the source of funding for the four teams to be established in Fiscal Year 2008. FEMA is also preparing a phased plan for Fiscal Year 2009 and out years to comply with Congressional direction to establish the remaining National and Regional teams.

    c. **The legislation specifically requires that the teams include a defense coordination officer, liaisons to other Federal agencies, and individuals from the**

agencies with primary responsibilities under each of the emergency support functions of the National Response Plan. Are such individuals on the existing teams? Will such individuals be included on teams that will be formed in the future?

The organization chart for the Regional and National IMATs notes that the Emergency Support Functions (ESFs) can be assigned as needed throughout the IMAT organization. Representatives from each of the other Federal partners that would make up the interagency response will be identified as Liaison Officers (LNO)s. These LNOs will be pre-designated and have the opportunity to train and deploy with the IMAT as needed.

d. What assets, equipment, and capabilities do the teams have?

The National IMAT will have 26 full time personnel; the Regional teams will have 15 full time personnel. In addition, the IMAT will be augmented by other interagency and homeland security partners. The IMAT deployment package consists of a full array of personal communications equipment including two vehicles that will have robust connectivity via data, voice and video networks.

The primary mission of an IMAT is to rapidly deploy to an incident or incident-threatened venue, provide leadership, Federal assistance, situational awareness, and coordinate the integrated inter-jurisdictional response in support of the affected State(s) or US Territories. When deployed the IMAT will:

- Establish a Federal presence within 12 hours
  - Stand up an initial JFO cadre and initiate sustained operations
- Provide initial situational awareness
  - Establish real-time mobile visual communications connectivity with the State EOC, and the FEMA/DHS NRCC/NOC
  - Provide input to COP
  - Establish connection with NORTHCOM and associated DoD elements
- Establish direct liaison with the State Emergency Manager
  - Place a liaison at the State EOC
  - Receive a State Coordinating Officer or liaison
  - Establish communications systems connectivity
  - Establish connection with State National Guard
  - Establish liaison with other local jurisdictions, NGOs, etc.
- Conduct joint Federal-State preliminary needs assessment
  - Evaluate the range of potential requirements for Federal assistance
  - Evaluate requirements for critical first stage actions
    - Evacuation and shelter of general population and medical special needs
    - Emergency medical support, feeding and overall victim assistance
    - Assess communications shortfalls
    - Assess requirements for basic commodities
    - Assess state and availability of health care

Gulf Coast Recovery

38. **On October 11, 2007, FEMA announced that it had established a reimbursement program that would provide relocation assistance to disaster victims displaced by Hurricanes Katrina and Rita. Even though some disaster victims have been struggling for some time to find the money to move back home, FEMA established this program more than two years after Hurricanes Katrina and Rita struck.**

    a. Why did it take FEMA so long to establish a reimbursement program?

FEMA actually began providing relocation assistance almost immediately after Hurricane Katrina, under the Facilitated Relocation Program, in which FEMA authorized and arranged transportation for evacuees to wherever they were able to find housing. However, the Facilitated Relocation Program was discontinued in February 2006, based on a legal determination that the agency did not have authority to continue the program. FEMA subsequently determined that the only legal method of providing such assistance was through the Other Needs Assistance (ONA) provision of the Individuals and Households Program (IHP). Since ONA was (at the time) cost-shared with states, each State was required to authorize ONA for this purpose. The State of Louisiana did not provide approval until Congress eliminated their cost-share in 2007.

Although Congress has waived the State cost share for Louisiana, Mississippi, Alabama, and Texas for Hurricanes Katrina and Rita disasters, by regulation, FEMA requires State concurrence to implement programs provided for under ONA. Therefore, each State had to agree to the provisions of the new program and agree to extend the ONA program past the initial 18 month period of assistance before Relocation could be implemented in their State. The FEMA Gulf Coast Recovery Office worked closely with each of the Gulf Coast States to establish the current program.

Since then, in partnership with the Gulf Coast States, FEMA has established a new Relocation Assistance Program in which FEMA would reimburse or advance financial assistance to applicants for relocation costs. Because the program is new, FEMA and the States had to develop supporting policy, eligibility criteria, rules, letters, and processing guidance.

In July, FEMA initially established the Relocation Assistance Program for Louisiana, and now is making the program more widespread to include all states affected by Hurricanes Katrina and Rita. The Gulf Coast Recovery Office has received more requests for relocation assistance as people are continuing to move back into their home states.

    b. Why is the end date for the program February 29, 2008?

The end date for the Relocation Assistance Program is February 29, 2008, because as mentioned above, the Relocation Assistance Program is provided under the Other Needs Assistance Provision of IHP, which has a State cost share. Although Congress has waived the State cost share for Louisiana, Mississippi, Alabama, and Texas for Hurricanes Katrina and Rita disasters, by regulation, FEMA requires State concurrence to extend the ONA program beyond the initial

18 month period of assistance. Currently, the States have requested the ONA program extension up to February 29, 2008.

The Associate Deputy Administrator for the FEMA Gulf Coast Recovery Office may extend the period of eligibility past February 29, 2008 if it is determined that doing so would be in the public's interest and with concurrence from the States.

39. **FEMA periodically requires households displaced by Hurricanes Katrina and Rita residing in FEMA funded housing to recertify their eligibility for assistance. According to some advocates, recertification efforts for victims of Hurricane Katrina have been confusing, poorly coordinated and often threatening, leading to fears that eligible households will be or have been cut off from assistance.**

    a. **What improvements do you think are needed in the recertification process and, if confirmed, what measures will you take to ensure that those improvements are implemented?**

Our goal is to clarify, simplify and communicate an improved recertification process in plain English that still maintains appropriate public stewardship of disaster relief funds. FEMA needs to improve how and what it communicates to the individual and the public about the conditions for receiving continued temporary housing assistance. Since Katrina, FEMA has put forth substantial efforts to revise the recertification process and is working towards the regulatory changes required as a long term solution. Verifying a need for continued housing assistance is complex, and FEMA will require the full support of other Federal and State agencies to collect information needed to quickly but accurately determine eligibility. It is also our intent to use available technology and information sharing agreements to lessen the burden on individuals to produce required information.

    b. **What steps can you take to assure us that the agency determines eligibility for housing or other assistance accurately and fairly, and that we will not have future instances in which FEMA finds victims to be ineligible for assistance only to subsequently find them eligible?**

- FEMA has implemented many recommendations made by the DHS Office of Inspector General and the GAO as well as other entities contracted to evaluate FEMA's program implementation in the wake of Hurricane Katrina. Through the use of technology, FEMA has increased its ability to certify an individual's identity and validate the pre-disaster address.
- FEMA has modified its written communication to applicants in an effort to provide a more detailed explanation of assistance determinations. The letters include information for applicants who wish to appeal the decision. Additionally, FEMA will send out informational reminders to applicants who need continued rental assistance advising them of requirements and needed documentation. These reminders will be sent in a timely manner so that applicants will have enough time to submit the necessary documents validating their housing need.

- FEMA is modifying its program explanation guide to provide a more detailed explanation of FEMA disaster assistance programs. The guide will include the types of documentation that applicants need to send to ensure that proper determinations can be made regarding their individual application.
- In the past year FEMA has enhanced the IHP case processing training modules to include several hours of hands-on case processing experience so that caseworkers are better prepared for their job. We have also implemented an annual recertifying requirement for caseworkers to ensure they are knowledgeable of the most recent IHP policies and procedures.
- In 2007 the NPSCs established the IHP Assistance Group which serves as a one-stop-shop resource center for FEMA caseworkers. The IHP Assistance Group has a single phone number employees can call to receive consistent and clear guidance on IHP questions. This group also tracks trends about IHP program questions and addresses training or policy guidance concerns as soon as the trend is identified.
- In 2007 the NPSCs enhanced the Quality Control program so that caseworkers receive performance feedback regarding the work they completed the previous day. Not only does this allow us to address processing errors quickly, timely feedback provides for a more meaningful coaching experience for the employee. Additional QC enhancements include a new "queue" that was recently added to NEMIS that allows the supervisor the opportunity to review all eligibility determinations processed by new employees and those with lower QC scores so that case processing errors are addressed in a timely manner.
- FEMA will continue to revise the recertification process to ensure the inclusion of less subjective criteria for eligibility as appropriate.
- FEMA will continue to improve communication materials and increase public awareness and understanding of recertification criteria.

40. **Serious concerns have been raised that the trailers that house victims of Hurricane Katrina contain elevated levels of formaldehyde, a potentially harmful substance used in materials used to construct the trailers. As of October 10, 2007, FEMA had received over four thousand requests from households asking to be moved out of their travel trailers, but had only successfully moved one-fourth of those applicants into alternate housing. What are the obstacles preventing the applicants from relocating more quickly and what plans does FEMA have to expedite this process?**

FEMA is actively working to relocate applicants that have formaldehyde concerns out of temporary housing units located throughout the Gulf Coast. Beginning in early 2006, FEMA began providing trailer residents with instructions on how to ventilate their trailers and provide residents with replacement trailers where the ventilation did not resolve the complaint. More recently, in July, 2007 FEMA distributed more than 70,000 formaldehyde and housing fact sheets to the occupants of FEMA trailer across the Gulf Coast, and is completing distribution throughout the rest of the country. The fact sheet provides additional information about formaldehyde, including possible medical effects and contact information for assistance. Beginning July 20, 2007 FEMA set up 24 hour, 7 days-a-week call centers for applicants living on group/commercial or private sites who have concerns, questions or request information about

formaldehyde. FEMA and the Secretary have made it clear that anyone who wants to move out of their temporary housing unit because of formaldehyde will be offered alternative housing.

Every person who has called FEMA's formaldehyde call centers with concerns or questions has been offered an immediate move to a hotel or motel until alternative housing is located. To date, 280 applicants have accepted hotel or motel accommodations. All of the 4,515 applicants who requested alternate housing have been offered alternative housing options. Of those, 1,204 have moved to another housing option. We are working with the remaining applicants as they make final decisions about their relocation alternatives.

In addition to hotels, motels, and rental units, FEMA may also swap the travel trailer with a mobile home (where feasible), or move the applicant into an available mobile home at another group or commercial site. FEMA is working with each applicant to identify the most appropriate housing alternative for each family. If an applicant would like to move to a rental unit, FEMA provides each applicant with a list of 1-5 available rental units that meet their individual housing needs for their consideration. The applicant can visit the rental units and selects which unit, if any, they prefer. FEMA then processes the applicant and landlord for rental assistance. Many landlords require background and/or credit checks, which can delay the process or preclude an applicant from a specific rental unit. The applicants still pending are at a variety of stages within the process. Some are visiting the identified rental units to determine which unit they prefer, some have told FEMA that they prefer to find their own rental unit, some are waiting for completion of background and/or credit checks, and others remain undecided about what they want to do. On October 10-12, 2007 FEMA re-contacted all of the pending applicants and once again offered to immediately move them to a hotel/motel until a more suitable alternative was arranged.

Affordable housing, particularly rental units, is limited in many areas along the Gulf Coast. However, FEMA has taken steps to increase the amount of available rental units and reduce the other barriers (security deposits, damage deposits, background check fees) that may slow the process for an applicant. FEMA redefined the current Corporate Lodging Consultants (CLC) contract on August 24, 2007, to improve landlord participation and the universe of rental properties by expanding lease provisions to include security deposits, cost of damages and application or background check fees.

FEMA developed job specific training for our housing caseworkers to assist them in communicating with the applicants. All of FEMA's field caseworkers have received this new training. FEMA is also implementing a Quality Assurance/Quality Control (QA/QC) process to ensure that our field staff are working aggressively and communicating effectively.

41. **In the summer of 2007, FEMA embarked on a program to test travel trailers and mobile homes for formaldehyde and other air contaminants.**

    a. **Describe in detail the design of the testing program. What agencies were involved in designing the testing program? What is the time table for completion of the testing?**

FEMA's overarching concern in emergency housing is the health and safety of disaster victims. Accurate information is imperative in order for FEMA to properly manage a safe, large scale emergency housing program and be responsive to oversight. FEMA worked closely with the Centers for Disease Control and Prevention (CDC) and the Department of Homeland Security's Office of Health Affairs (OHA) to design a comprehensive, scientifically-sound, NIOSH certified testing program that will yield the data to build the information and support sound policy decisions.

There are three fact finding elements of the testing program. The first element has two components. (a) to conduct the air sample, obtain a reading of the formaldehyde and provide this information to the resident so that the resident can make an informed decision to remain or relocate from the temporary housing unit; and (b) to sample a statistically valid number of occupied and unoccupied housing units to determine if formaldehyde levels in these units can be characterized as to make, model, location, or date of manufacture.

The second element involves researching and assessing the effectiveness of mitigation strategies to reduce formaldehyde levels in emergency housing units. The third element examines the possible association of observed indoor air quality in occupied units with adverse health effects of children occupying the units.

CDC was responsible for determining the testing protocols and a statistically valid sample size for each of the three elements, including selection of instruments for assessing the formaldehyde level. CDC is also responsible for selecting mitigation strategies from across the body of work in this area for more detailed assessment.

The air sampling to determine the formaldehyde level is expected to begin in early December. The preliminary result for the examination of mitigation strategies for formaldehyde in housing units) is due this fall (2007), and the results of the long-term health effects are due in October 2008.

Knowing that accurate scientific information -- with no accepted standards against which to apply it -- would require a lengthy, deliberate process, FEMA worked with occupants and their advocates to ensure those with health concerns were offered a range of immediate housing alternatives. That effort continues.

b. Does the test design have any method for testing the health risks of prolonged exposure to an elevated area of formaldehyde?

The third element described above, the long term health effects for children, is focused specifically on health risks from exposure to formaldehyde and other indoor environmental indicators. These indicators include mold, mites, animal dander, carbon dioxide, antigens, and humidity, in addition to formaldehyde.

c. What efforts have been made to notify the families of the potential health risks of formaldehyde exposure in FEMA provided travel trailers and mobile homes?

Following the initial complaints of elevated formaldehyde levels and subsequent testing by the Environmental Protection Agency, with analysis and recommendations from the CDC Agency for Toxic Substances and Disease Registry, FEMA prepared information packets for emergency housing unit occupants. In July 2006, FEMA distributed the brochures to trailer occupants across the Gulf Coast advising occupants how to recognize elevated formaldehyde, how to reduce levels through ventilation and temperature moderation, recommended limiting exposure and offered other resources including a hotline (866-562-2381) and web sites to help inform and enable decisions based on personal factors. The toll free hotlines have been active since July 2007 and handled approximately 16,000 calls through the national hotline and 6,000 calls have been transferred to the Gulf Coast for further assistance. Of these calls, over 3,500 have been transferred to CDC with specific health questions.

d. How many travel trailers or mobile homes have been tested so far? When did the testing start? What are the preliminary results of the testing?

Testing of occupied units has not begun. CDC will begin testing of 300 housing units (150 in Louisiana, 150 in Mississippi) in December. CDC National Institute for Occupational Safety and Health (NIOSH) has taken preliminary air quality samples from unoccupied, unvented units. They used this information to design the mitigation assessment. They are partnering with the Lawrence Berkley National Laboratories, studying the off-gassing of components of emergency housing units.

e. What types of precautions or testing does FEMA or the DHS Office of Heath Affairs plan to use to examine travel trailers and mobile homes prior to transferring them to the General Service Administration, Indian tribes, or others?

In July, 2007 FEMA ordered a hold on all issuances, transfers, sales or donations of travel trailers and park models until the assessments are complete. Once the characterization assessments and mitigation strategies recommendations are received from CDC, FEMA will re-evaluate this policy and establish a program that allows for the safe transfer of units.

42. **The Stafford Act provides for assistance where the severity of the storm is beyond the capacity of State and local governments.**

    a. **How does FEMA calculate the impact of the disaster at the "local government level" in states that do not have county government and what is the required damage per capita?**

Factors considered by FEMA when evaluating a State request for a disaster declaration are outlined in 44 CFR Section 206.48. These factors include the availability and coverage of insurance, State assistance programs, voluntary and donated assistance, and other federal agency (OFA) assistance programs.

Additional evaluation factors for Individual Assistance Programs include:

1. Concentration of damages to individuals. High concentrations of damages generally indicate a greater need for federal assistance than widespread and scattered damages throughout a State.
2. Trauma. The degree of trauma to the State and communities are considered, with special attention to large numbers of injuries and deaths, large scale disruption of normal community functions and services, and emergency needs such as extended or widespread loss of power or water.
3. Special Populations. Disaster-impact on special populations such as the low-income, the elderly or the unemployed are considered. Special consideration is also given to the effect of the disaster on American Indian and Alaskan Native tribal populations.
4. Voluntary agency assistance. The capabilities of the local and State voluntary, faith, and community-based organizations are taken into consideration, as these entities play an important role in meeting both the emergency and recovery needs of individuals impacted by disasters.
5. Insurance. Stafford Act assistance is supplemental in nature and therefore insurance coverage is taken into account to avoid the provision of duplicative assistance.
6. Average amount of individual assistance by State. While there is no set threshold for recommending Individual Assistance, FEMA has determined the average amount of assistance to individuals and households provided over a five year period. This information may be useful to States and voluntary agencies as they develop plans and programs to meet the needs of disaster victims.

In addition to the factors mentioned above, additional conditions are considered when making a recommendation for a major disaster declaration, including community isolation, unique or diverse cultures, repetitive damages caused by numerous disasters in a short time frame, imminent health concerns or extreme poverty. The prevalence of these conditions may lead to a post-disaster environment that overwhelms local and State recovery capabilities and warrants supplemental federal disaster assistance.

FEMA has also convened a workgroup to evaluate current declaration request review factors. Workgroup recommendations are currently under development. The workgroup includes State representation identified through the National Emergency Management Association (NEMA).

b. What commitment will you make to ensuring that FEMA will fairly calculate the impact of disasters at the local government level in states that have no county government?

FEMA will evaluate data based on the geographic area of impact. For individual assistance, the impacts to individuals and households can be determined without the existence of a county government; for instance, areas of Alaska that are officially "unorganized" (lack a borough government) are assessed and designated geographically based on regional educational areas.

Grants

43. **Homeland security grants are the principal means DHS has to ensure that State and local governments are prepared for all hazards, whether natural or manmade. This year, FEMA will distribute over $3 billion to State and local governments, port and transportation system operators, and first responders. How will you ensure these grants are effectively building our national capabilities to respond to – and, in the case of terrorist attacks and other manmade incidents, prevent – disasters?**

If confirmed as the Deputy Administrator of FEMA, I will continue to ensure that all preparedness grant programs administered by the Grant Programs Directorate within FEMA support the achievement of the National Preparedness Guidelines and its National Priorities, the building and sustainment of preparedness capabilities over the long-term, and the implementation of a common framework grounded in capabilities-based planning. Although each grant program has been designed to support a specific purpose, the policy priorities driving each program are mutually reinforcing and ultimately contribute to raising the preparedness baseline nationally.

The grant program guidance that is developed annually, as well as the application tools that states and urban areas use to frame their funding requests, all link directly back to the National Priorities and the 37 capabilities outlined in the Target Capabilities List. FEMA will continue to emphasize this alignment, as well as the criticality of taking an outcome-based approach to investing preparedness grant funds. Proposals from applicants are aligned with the National Priorities and must outline measurable outcomes that will be tracked and accomplished during implementation. Grantees report on progress made toward achieving the identified outcomes for each investment as part of the regular grant reporting process. The performance measure data submitted through grant reporting will be reviewed and validated through programmatic monitoring by FEMA personnel to ensure that the grants are achieving intended outcomes and that the funds effectively build our national capabilities to prevent, protect against, respond to, and recover from disasters.

In addition to continued reporting and monitoring, I believe that the State Preparedness Reports, which will be submitted by each State annually beginning in Fiscal Year 2008, will also help provide insight into the progress made by state all-hazards preparedness programs, the accomplishments that have been achieved, and the grant funds from DHS and other agencies that have supported those activities. The report will enable states to clearly outline to DHS and

Congress their accomplishments in achieving progress toward the National Priorities and how they will continue to leverage a wide spectrum of resources to increase preparedness.

44. **The Post-Katrina Act gave FEMA the responsibility for administering all DHS grants to State and local governments. A single geographic area may receive funds from many distinct grants awarded by FEMA – the State Homeland Security Grant Program, the Urban Area Security Initiative, port security grants, transit security grants, interoperable communications grants, Emergency Management Performance Grants and more. To be most effective, those grants need to be allocated and used in a coordinated fashion, to work together to promote preparedness in that area. If confirmed, how will you ensure that each of the Department's grants in a single geographic area work synergistically to promote preparedness?**

The Post-Katrina Act has transferred several preparedness missions, functions, staff and programs from other components of the Department to FEMA, providing FEMA with an unprecedented opportunity to shape all aspects of the Nation's domestic homeland security posture. The integration of such missions with FEMA's existing preparedness programs at the Regions will inevitably result in improved synchronization of preparedness efforts. Further, the integration will strengthen our ability to deliver to the American people a robust and effective means of building homeland security capabilities, spanning Federal, State, and local communities, and the private sector.

If confirmed as Deputy Administrator of FEMA, I will continue to emphasize that the entire grant portfolio we administer needs to be allocated and used in a coordinated fashion to promote holistic State and local preparedness. The grant programs managed by FEMA can be grouped into two broad categories: (1) overarching homeland security programs that provide funding for a broad set of activities in support of the four homeland security mission areas and the National Preparedness Guidelines; and, (2) targeted infrastructure protection programs for specific critical infrastructure protection initiatives within identified jurisdictions. Overarching grant programs are wide-reaching initiatives that fund planning, organization, equipment, training, and exercise activities in support of the Guidelines and related national doctrine, such as the National Incident Management System (NIMS), National Response Framework (NRF), and the National Infrastructure Protection Plan (NIPP). Targeted infrastructure protection programs include grants for specific activities that focus on the protection of critical infrastructure, such as ports, mass transit, highways, rail transportation, etc. Although guided by a common preparedness framework outlined in the National Preparedness Guidelines, each program also maintains a unique set of priorities guided by applicable national policy documents, as well as legislative requirements.

If confirmed, I will work to ensure that the grants directed to a single geographic area work synergistically to promote preparedness by emphasizing the importance of all-hazards risk analysis at the State and local level and how this process can inform capability requirements and associated resource needs. Moreover, FEMA, in conjunction with its partners across DHS and the interagency, will continue to work with States, local jurisdictions, and the owners and operators of critical infrastructure to align their preparedness efforts with the priorities outlined in national doctrine as well as state and local strategic and operational planning processes. Our

regular reporting and monitoring processes, as well as sustained engagement directly with stakeholders, will provide a key mechanism to ensure that grantees are leveraging multiple funding streams appropriately. These efforts will be facilitated greatly by the overarching goal of more robust FEMA Regions and the transition of preparedness programs to the Regions.

To facilitate the realignment of preparedness into FEMA using a Regional model, we have convened a Regional Working Group (RWG), which includes representation from each of the FEMA regions as well as specific headquarters contacts for GPD and NPD. This working group has taken a broad look at how we are going to most efficiently and effectively move Preparedness to the Regions. The RWG is addressing many issues including the transfer of staff to the Regional Administrators, the overall integration of the preparedness mission into the regions, and business process improvements. Within the larger RWG, a grants management sub-team has been established to address the regionalization of the multi-billion dollar portfolio of preparedness grants. This group made significant strides outlining which functions would best be performed in the Regions and for which programs.

In addition, each Region is hiring a Federal Preparedness Coordinator (FPC). The FPC will be responsible for providing guidance, strategic consulting, and assistance related to building regional preparedness capabilities across multiple levels of government, jurisdictions, disciplines, critical infrastructure sectors, and citizen groups. The marriage of the FPC mission and the grant programs being regionalized will result in a coordinated Regional and National Preparedness framework.

I plan to personally oversee the facilitation of the development of Regional preparedness strategies, plans, priorities, goals and objectives and review the annual and multi-year planning documents. These strategies, plans and goals will be consistent with applicable national preparedness policies, standards, and guidance, set forth by the National Preparedness Directorate, Grant Programs Directorate, and other FEMA components with lead preparedness functions.

TOPOFF

45. **DHS recently completed the Top Officials 4 (TOPOFF 4) exercise. What types of preliminary after-action reports or hotwashes will be completed and when do you expect those to be completed? Will you provide a copy of any such reports HSGAC?**

The TOPOFF 4 after action process includes data collection, reconstruction of events, and analysis of exercise play and decisions to identify strengths and areas for improvement from the exercise.

Within this process four documents will be created and it is our intent to release all four reports to the HSGAC:

1. **Quick-Look Report**: A high-level document with essential information on the initial strengths and findings of the TOPOFF 4 Full Scale Exercise. This report was distributed to State and local exercise participants and the Federal Interagency.
2. **Summary of Findings for Public Release**: This document identifies key strengths and findings within the TOPOFF 4 Full Scale Exercise and the recommended actions to address those issues. This document will be distributed to all States through their Homeland Security Advisor as well as to the public.
3. **Final TOPOFF 4 After Action Report**: This document reflects the conclusions reached throughout the TOPOFF 4 AAR process, providing a comprehensive analysis of the results of the TOPOFF 4 Full Scale Exercise and information concerning the implementation of action items. Once approved, AAR will be distributed to Federal, State, and local exercise participants and other need-to-know participants approved by the DRG Sub-PCC.
4. **Executive Overview of the AAR:** this document is a high-level overview of the AAR, outlining how each target capability involved in the TOPOFF 4 Full Scale Exercise was addressed. This document will be made available to Federal, State, and local exercise participants, as well as all other states through their Homeland Security Advisors.

In addition to these four documents, the Department of Homeland Security will share TOPOFF 4 lessons learned and best practices taken from the after action process with the homeland security/responder community by posting the information to the Department of Homeland Security's Lessons Learned Information Sharing (LLIS.gov) system. This effort occurs after the creation of each after action document and remains ongoing. LLIS.gov is available to more than 40,000 constituents within the homeland security/responder community. The Department of Homeland Security will also host a TOPOFF 4 National After-Action Conference in February 2008 to present the strengths, recommendations, and lessons learned from the TOPOFF 4 Exercise Series to homeland security constituents representing various governmental bodies, including the Federal Interagency, State governors' offices, State Homeland Security Advisors, emergency management officials, and Urban Area Security Initiative grantees.

Revision of the National Response Plan

46. **In a February 2007 report, GAO found that the National Response Plan did not fully reflect the capabilities of several agencies with supporting roles in the provision of disaster housing assistance, and that many of the supporting agencies had not developed fact sheets about their roles, procedures, and authorities as required by standard operating procedures. Recognizing that FEMA has overall responsibility for the NRP yet these shortcomings limited FEMA's ability to effectively coordinate housing assistance, GAO recommended that these agencies propose revisions to the NRP that would clearly lay out their capabilities to house disaster victims and develop the required fact sheets.**

    a. **To what extent does the recent draft National Response Framework incorporate more comprehensive information about these housing agencies' capabilities?**

The draft National Response Framework reflects changes to Emergency Support Function (ESF) #6, which has been updated from the National Response Plan (Mass Care, Housing, and Human Services) to "Mass Care, Emergency Assistance, Housing, and Human Services, and references the National Disaster Housing Strategy. The Strategy reflects the housing capabilities of Federal departments and agencies and comprehensively defines housing assistance, including: direct housing operations, a hotel/motel program, non-congregate facility housing, and financial assistance for housing, temporary roof repair, rental assistance, assistance for permanent construction, a repair program, replacement program, availability of the Small Business Administration Disaster Loan Program, transportation to other locations, and the establishment of central housing resource information.

b. How would you characterize the Department's ability to assure that support agencies take steps needed to assure FEMA's ability to effectively deploy housing assistance to disaster victims?

FEMA has worked hand in hand with its Federal partners to further articulate capabilities and coordination points through a revised Emergency Support Function (ESF) #6 Annex to the NRF and a detailed ESF #6 Standard Operating Procedure (SOP). The annex outlines comprehensive ESF #6 roles and responsibilities in the delivery of mass care, emergency assistance, housing, and human services for FEMA and all supporting agencies. The SOP outlines staffing responsibilities, coordination requirements, resource and information sharing requirements, draft mission assignments, and job aides for ESF #6 operations staff.

To further enhance housing capabilities, FEMA has engaged Federal, State, and local partners to develop a National Disaster Housing Strategy (NDHS). The purpose of the NDHS is to convey national guidance, operating principles, and a vision for public (Federal, State, tribal, local), private, and non-profit cooperation in providing disaster housing assistance. It defines the roles, programs, authorities, and responsibilities of all entities, detailing shared responsibilities and emphasizing the cooperative efforts required to provide disaster housing assistance. The NDHS further outlines the most efficient and cost-effective options for meeting disaster housing needs. The NDHS is in the final development stages.

During the California fires, FEMA and other Federal agencies established a national Housing Task Force at the headquarters level while simultaneously FEMA and the State of California have established a Joint Housing Task Force to implement a housing strategy to address the housing needs resulting from the California wildfires. The agencies involved included, but were not limited to, the Corporation for National and Community Service, Department of Agriculture, DHS Office of Civil Rights & Civil Liberties, Department of Defense (including the U.S. Army Corps of Engineers), Department of Housing and Urban Development, Department of Health and Human Services, Department of Interior, Department of Justice, Department of the Treasury (including the Internal Revenue Service), Department of Transportation, Department of Veterans Affairs, General Services Administration, and the Small Business Administration. Other organizations involved were the American Red Cross and National Voluntary Organizations Active in Disasters.

c. To the extent that the Department's ability is hampered, how can any limitations be overcome?

The interagency effort has supported and continues to support the NRP/NRF extremely well. In terms of interagency engagement, and willingness to engage, the Department is not hampered. Our recent collaborative responses to disasters, notably the California Wildfires, have vivified a fully engaged and proactive federal response and recovery community and demonstrated its effectiveness. However, the Department has found itself hampered, at least from a public and Congressional perspective, by certain legislative and regulatory limitations which prevent us from meeting their high expectations. While FEMA is actively reviewing and revising regulations which support Stafford Act implementation, we do not have the ability to operate outside legislative requirements.

For example, while FEMA supports the post-Katrina findings which recommend that the disaster housing (as opposed to sheltering) mission be transferred to HUD, HUD's ability to assume that mission is hampered by the legislative framework within which their existing programs are delivered. In order for HUD to effectively assume the disaster rental assistance mission, they require legislation establishing authorities they do not currently have.

47. **The Post-Katrina Act emphasized that FEMA must build strong relationships with state and local stakeholders for emergency management if it is to successfully respond to a disaster. According to some of the stakeholders involved in the initial redrafting of the National Response Framework (NRF), the version released by DHS for comment in early September 2007 was substantially different than an earlier consensus version that had been worked on with the key stakeholders. Some of the stakeholders had substantive criticisms of the draft NRF released for comment. What steps are you taking to vet comments and ensure that the views of FEMA's state and local partners are appropriately incorporated in the new Framework?**

DHS/FEMA received over 160 comments on the NRF base document, the accompanying overview and partner guides. DHS/FEMA has instituted an aggressive outreach effort with stakeholders to provide ongoing status regarding finalization of the National Response Framework and adjudication of proposed changes. Administrator Paulison and I met with representatives from the International Association of Emergency Managers (IAEM) to discuss their comments and offered a similar session to representatives from the National Emergency Managers Association (NEMA). The DHS/FEMA writing team is reviewing input to the NRF and cross-walking comments against earlier drafts to ensure no stakeholder input or comments are overlooked and all are adjudicated for potential inclusion. DHS/FEMA is committed to a transparent and consultative process to ensure all stakeholders understand the status and treatment of submissions of proposed changes.

V. Relations with Congress

48. **Do you agree, without reservation, to respond to any reasonable summons to appear and testify before any duly constituted committee of the Congress if you are confirmed?**

Yes.

49. **Do you agree, without reservation, to reply to any reasonable request for information from any duly constituted committee of the Congress if you are confirmed?**

Yes.

50. **The Committee is concerned about the lack of DHS cooperation with GAO. What steps will you take to ensure GAO has reasonable and timely access to your program officials and relevant information?**

FEMA recognizes the importance of a positive relationship with the Government Accountability Office (GAO) and works hard to maintain this relationship. In my previous assignments in the Coast Guard, I maintained excellent relationships with GAO. Since taking on my current responsibilities, I have met with senior GAO officials and believe that we have taken steps to improve the historical relationship between FEMA and GAO. I am committed to a continuous process of improving the level of communication and cooperation.

Many of the concerns raised by FEMA and GAO have been related to the timely availability of information, the accuracy of information, and the access to FEMA program officials. To address these concerns, FEMA established the GAO liaison office. FEMA has asked, and GAO leadership has agreed, that GAO engagements be coordinated through the process established by this liaison office. This has already resulted in an increased response rate and faster turn-around times for appointments and queries.

FEMA audit liaison personnel meet with the GAO staff on a regular basis to identify and exchange information on all aspects of open engagements and recommendations. They are working together to identify and compile an accurate list of recommendations and the status of their corrective action plans (CAPs). The expected result is fewer misunderstandings and better responsiveness by both GAO and FEMA staffers.

FEMA has established an interim GAO tracking system to monitor and report on engagement and recommendation status. It includes the identification, tracking, and notification procedures required to follow the engagement from initiation to recommendation close-out (often a multi-year timeline). The result has been faster turnaround time for GAO requests, better awareness by FEMA programs of their responsibilities to different GAO engagements, and improved visibility by FEMA leadership into the status of our GAO engagements and recommendations.

FEMA's current tracking system contains the total number of known GAO engagements and their related recommendations. The recommendations and the tracking database are regularly updated, giving FEMA audit liaison personnel and their GAO counterparts current visibility into our progress. We have tasked all offices within FEMA to provide a status update to all critical engagements and recommendations by the end of November.

FEMA is developing an advanced master database in Microsoft Sharepoint that will provide additional information on engagements, including enhanced notification, report generation, and engagement/recommendation status. This capability will be available by the end of the year. The current database will be migrated to this new system. Both FEMA tracking systems were developed to meet all current laws, rules and regulations for generally-accepted auditing practices. This includes OMB A-50, OMB-123, DHS Management Directives 0820, and FEMA guidance.

As the relationship with the GAO continues we hope to be able to improve coordination by working through issues such as different uncoordinated GAO teams duplicating requests for information, GAO investigators not working with the liaison office, and working to address the sheer volume of requests that have absorbed a tremendous amount of staff time also needed for operation and transformational needs. We look forward to continuing this partnership in the future.

VI. Assistance

51. **Are these answers your own? Have you consulted with DHS or any interested parties? If so, please indicate which entities.**

I consulted with DHS and FEMA officials and subject matter experts in the development of the responses to these questions so that I may be able to provide to the Committee the most accurate and complete responses.

AFFIDAVIT

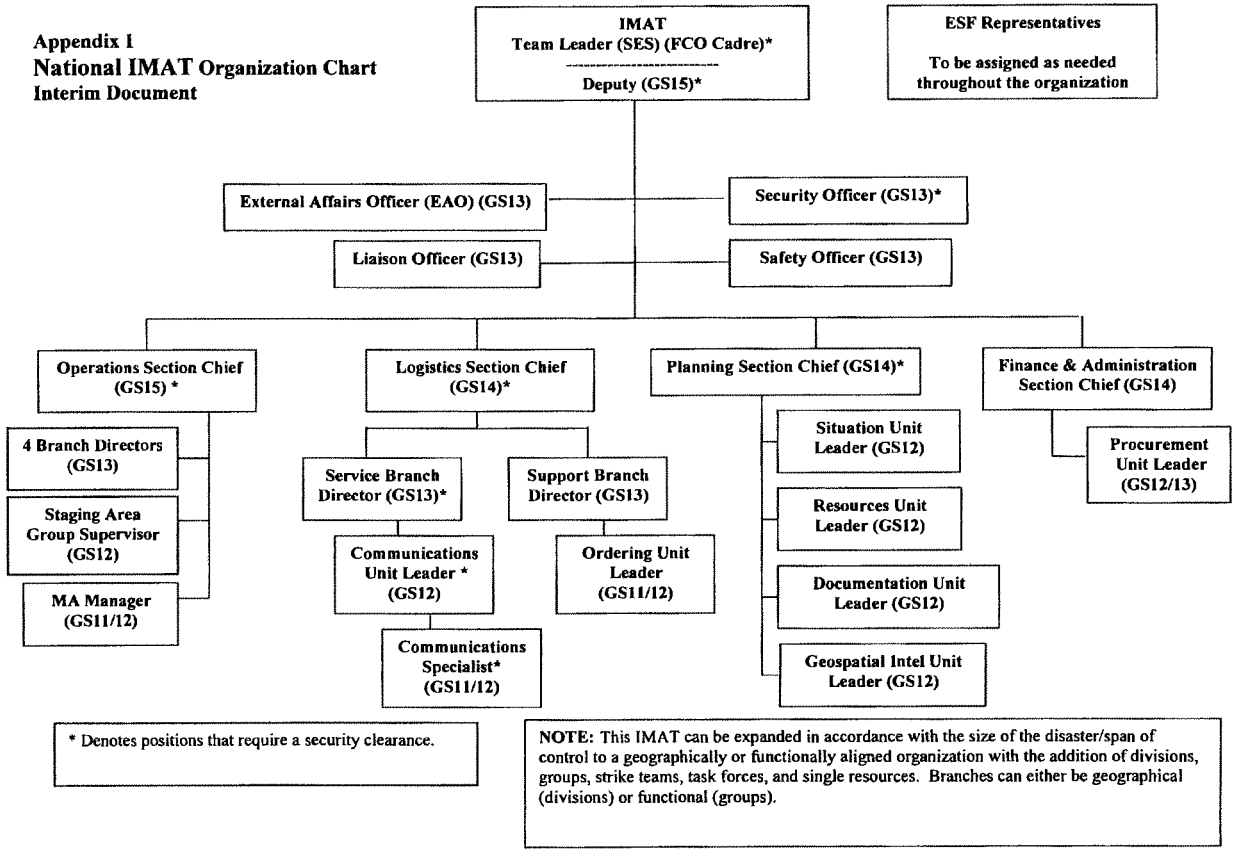
I, Harvey E. Johnson, being duly sworn, hereby state that I have read and signed the foregoing Statement on Pre-hearing Questions and that the information provided therein is, to the best of my knowledge, current, accurate, and complete.

Harvey E. Johnson

Subscribed and sworn before me this 26th day of November, 2007.

Loretta Schaffer
Notary Public

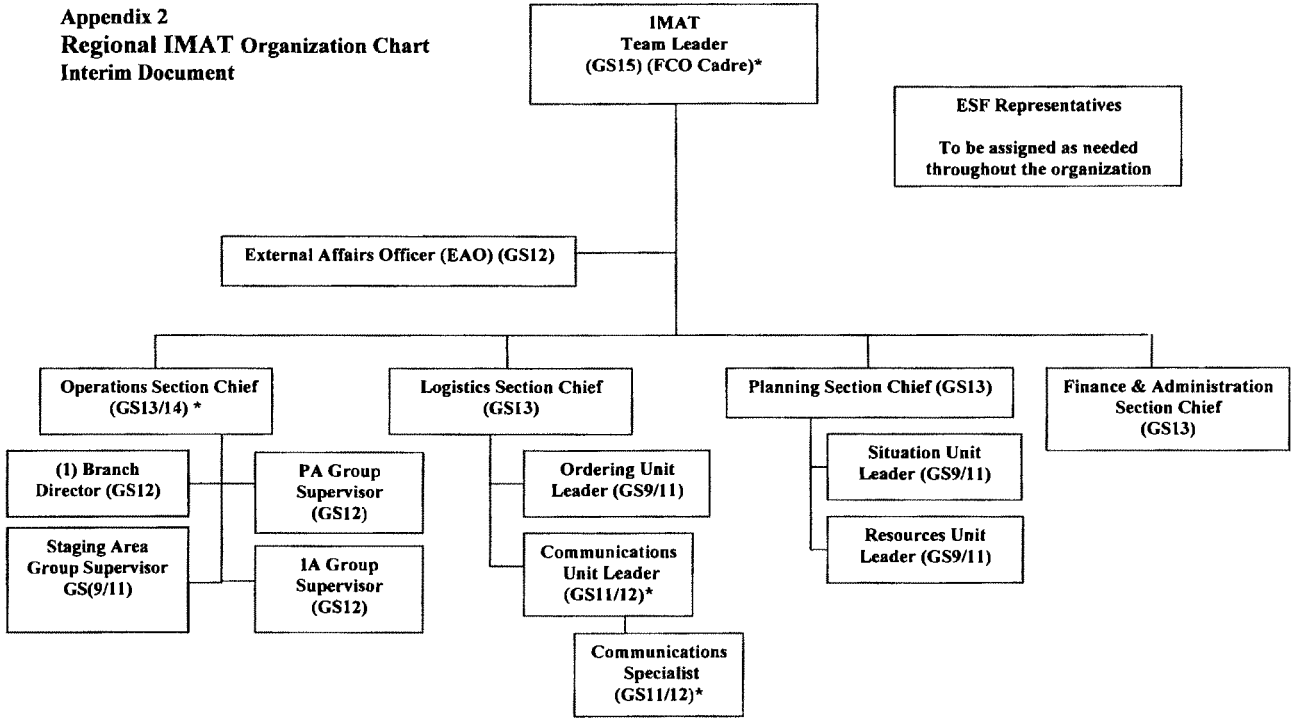
Appendix 1
National IMAT Organization Chart
Interim Document



* Denotes positions that require a security clearance.

NOTE: This IMAT can be expanded in accordance with the size of the disaster/span of control to a geographically or functionally aligned organization with the addition of divisions, groups, strike teams, task forces, and single resources. Branches can either be geographical (divisions) or functional (groups).

Appendix 2
Regional IMAT Organization Chart
Interim Document



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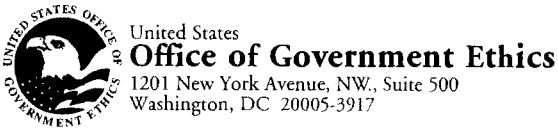

September 14, 2007

The Honorable Joseph I. Lieberman
Chairman
Committee on Homeland Security and
Governmental Affairs
United States Senate
Washington, DC 20510-6250

Dear Mr. Chairman:

In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Harvey E. Johnson, Jr., who has been nominated by President Bush for the position of Deputy Administrator and Chief Operating Officer at the Federal Emergency Management Agency, Department of Homeland Security.

We have reviewed the report and have also obtained advice from the Department of Homeland Security concerning any possible conflict in light of its functions and the nominee's proposed duties. Also enclosed is a letter dated September 13, 2007, from Mr. Johnson to the agency's ethics official, outlining the steps Mr. Johnson will take to avoid conflicts of interest. Unless a specific date has been agreed to, the nominee must fully comply within three months of his confirmation date with any action he agreed to take in his ethics agreement.

Based thereon, we believe that Mr. Johnson is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

Robert I. Cusick
Director

Enclosures

Senator Joseph I. Lieberman
Additional Questions for the Record
Nomination Hearing of Harvey E. Johnson, Jr.
December 12, 2007

1. **Last month, the Government Accountability Office (GAO) issued a report that was highly critical of Federal Emergency Management Agency's (FEMA) management and oversight of contracts awarded to maintain mobile homes, travel trailers, and group sites in Mississippi. GAO estimated that FEMA may have wasted almost half of the $60 million it spent between June 2006 and January 2007 for the contracts GAO reviewed. GAO, however, only looked at contracts in Mississippi for a 6-month period.**

   a. **Although GAO only looked at a six month period, the conditions GAO identified existed over a longer period and in other locations other than Mississippi. What actions is FEMA taking to assess the risk for fraud, waste and abuse across the range of locations and contracts that FEMA awarded?**

   ANSWER: FEMA intends to conduct an internal audit to determine whether or not it overpaid any of its Maintenance and Deactivation Contractors or Group Site Maintenance Contractors. It will assert claims against any contractor for the appropriate amount as a remedy under the Contract Disputes Act. Accordingly, FEMA will carry out these actions and recoup any overpayments to contractors. To assist in this effort, FEMA has asked GAO for specific instances of overpayment or fraudulent payments it discovered. GAO indicated they have forwarded instances of fraudulent invoicing to the Department of Justice (DOJ) and the Department of Homeland Security, Office of Inspector General (DHS OIG) for further investigation. FEMA is currently waiting on a response from DOJ and DHS OIG on whether or not FEMA paid fraudulent invoices. FEMA will cooperate fully with the US District Attorney and the DHS Office of Inspector General in their investigations regarding fraud, waste and abuse under the Maintenance and Deactivation Contracts (MDCs).

   To prevent issues from arising on the most current MDC task orders, FEMA has been conducting ongoing quality assessments of the MDC contractor performance within each of the Gulf Coast States. FEMA developed a new standard operating procedure for implementing a Quality Assurance Surveillance Plan (QASP) in June 2007, which measures timeliness, quality, and customer satisfaction of MD contractor performance uniformly across the Gulf Coast. Each month, all maintenance, emergency maintenance and deactivation work orders are sampled for each contractor and then evaluated against specific criteria outlined in the QASP. The evaluated work orders are then assigned a score. Each monthly score is reviewed with the contractor and guidance is given on how to improve. At the end of each quarter, the sampled work orders are evaluated. Based on the scores, an incentive or disincentive of anywhere from +15% to -15% of the invoiced amount is applied to each contractor. The new plan focuses on ensuring timely delivery of quality services to FEMA housing applicants throughout a trailer life cycle.

Additionally, all COTRs have been trained on the use of the National Institute of Health's Contractor Performance System and in conjunction the contracting officers are required to input performance records on each of the MDCs.

b. Does FEMA have any recourse to recoup those funds that may have been wasted? If so, what is FEMA doing to recoup those funds and how much has been recouped?

ANSWER: FEMA does have recourse to recoup any payments incorrectly made to contractors. Additionally, any payments made for which fraud has been involved may result in the suspension or debarment of those firms. The Agency is awaiting DOJ and DHS OIG findings on fraudulent payments.

2. **In its November 2007 report, GAO also found that FEMA paid one contractor a total of $1.8 million to clean septic tanks at one of the trailer parks, at $245 per cleaning. But this contractor merely turned around and had a subcontractor do the work for about $300,000, or $45 per cleaning; thus the contractor reaped a profit of almost $1.5 million. GAO pointed out that the contract reserved FEMA the right to use other sources to perform the work of cleaning the septic tanks, but FEMA never exercised that option. Why didn't FEMA act to save over $1.5 million by contracting directly with the subcontractor who could do the work for $45 per cleaning?**

ANSWER: Many temporary housing unit maintenance services were grouped together within the MDCs, including servicing power poles, refurbishing travel trailers or mobile homes, cleaning septic tank/bladders, and performing emergency maintenance. This was done intentionally to ensure that one contractor would be held accountable for all aspects of maintaining each temporary housing unit. Septic/bladder cleaning was not projected to be a major item based on historical requirements; therefore its weighted cost within the cost proposals did not figure greatly during the award process or determination of work distribution. In fact, McLeod Park is in a remote location and was, due to lack of connections to a city sewer system, the only park that required septic/bladder cleaning in that contractor's assigned region. The fixed price requirement was $245.00 for up to 260 gallons, including transportation and disposal. Because of the fixed price nature of the contract, FEMA does not have access to subcontractor's pricing data and therefore was not aware of the inordinately low price and substantial profit rate on that line item.

Due to high costs of performing septic bladder services, FEMA is deactivating these units as quickly as possible. As of 6 December 2007, the active units have gone from 62 units to 38 units. As discussed earlier, establishing a contract solely for the purpose of septic/bladder cleaning would have eliminated the benefits gained from having a single contractor responsible for the maintenance effort. Finally, the contractor in question was not successful in the second-year task order re-compete; therefore, FEMA is no longer paying that contractor for those services. Since June 2007, the new contractor's rate for

this service is $153.47, and $8,287 has been paid to the new contractor on this requirement. This represents a reduction of over $91.53 per service call.

3. **This is not the first FEMA has had a contractor pass through work to a subcontractor, or to layers of subcontractors. The same situation occurred with contracts to install blue tarps and to haul debris – FEMA hired one contractor, who then hired a subcontractor, who then hired another subcontractor, and so on and so forth. The company installing the blue tarp or hauling the debris got paid only a fraction of the amount FEMA paid to the prime contractor. The Committee has been very concerned about these situations, which result in excessive pass-through charges. In the Post-Katrina Emergency Management Act that was signed into law in October 2006, Senators Lieberman and Collins co-authored a provision to require the Secretary of the Department of Homeland Security (DHS) to develop a regulation for disaster-related contracts that would eliminate the excessive use of subcontractors to perform the principal work of the contract.**

   a. **Why has DHS failed to implement this provision?**

   ANSWER: The Department is in the process of amending the Homeland Security Acquisition Regulation (HSAR) to implement section 692 of the Post-Katrina Emergency Management Act. This new HSAR policy will apply not only to FEMA contract actions, but will also cover all DHS components responding to these types of situations. Because we are implementing section 692 via regulatory rulemaking, public comments are required before we can make this requirement final.

   b. **Is FEMA any better positioned today to know whether it is being charged fair and reasonable prices or to identify and eliminate excessive pass-through charges?**

   ANSWER: FEMA acknowledges that it did not have an adequate contract oversight structure in place at the time the MDCs were awarded and in the following months. At the time of Hurricane Katrina, FEMA's acquisitions office had approximately 35 people. Employment slowly increased in the following months despite the increased need for more contracting staff; nonetheless, FEMA obligated $6.9 billion in funds and over 11,400 contract actions in FY06. In addition to a shortage of Contracting Officers (COs) to effectively administer these contracts, there was a lack of Contracting Officer Technical Representatives (COTRs) to properly perform day-to-day oversight activities.

   In response to the need for more effective oversight on these contracts and others in the Gulf Coast including the Group Site Maintenance Contracts (GSMCs), FEMA has implemented several initiatives and is now better positioned to ensure prices are fair and reasonable, eliminate excessive pass-through charges, and improve its contract administration practices:

   1. FEMA's new robust Office of Acquisition Management (OAM) now has 166 PFT positions and 118 of these are 1102-series contract specialist positions. In addition,

OAM has temporary FEMA personnel supporting acquisitions at headquarters and the various Total Recovery Offices (TROs) in the Gulf Coast. The number of COTRs overseeing the MDC, GSMC, and other contracts in the Gulf Coast has more than doubled since January 2007 (the end of GAO's period of analysis).

2. A robust COTR program was developed to ensure higher levels of contract management and oversight. This initiative has been successful and has accomplished the following:

   - Implemented a tiered COTR certification program
   - Shaped the COTR workforce to ensure a higher level of competency and professionalism
   - Complied with Department of Homeland Security (DHS) and Office of Management and Budget (OMB) regulations and policy while leveraging best practices
   - Established a COTR community website

   Through the use of this program and improvement of contract management and oversight, FEMA has subsequently improved its invoice approval and payment process.

3. FEMA has put in place policies and procedures for the use of Contract Administration Plans (CAPs) which are designed to facilitate efficient and effective contract administration. The CAPs outline the required level of contractor performance surveillance, the contract terms and conditions for contract administration, performance milestones, and reporting requirements. FEMA has successfully used a CAP for Individual Assistance – Technical Assistance Contracts (IA-TAC) II for the past 18 months. Additionally, a CAP was implemented for the New Orleans Amtrak Evacuation Train contract.

   CAPs improve the Agency's post-award contract execution, by providing consistent guidance on ordering, competing, and administering procedures for task orders on task order-type contracts. They also promote task order competition while ensuring that services are available expeditiously to meet critical disaster response needs, and they establish consistent enterprise-wide contract administration processes for the COTRs in various regions.

4. **One of the issues that GAO identified in its November 2007 report was the lack of competition between the contract holders for specific tasks. For example, FEMA awarded 10 contracts in Mississippi for maintenance and deactivation of trailers. But instead of having those 10 contractors compete for specific work, FEMA awarded each contractor an equal amount of work – even though some contractors' bid prices were much higher than the prices of others. You indicated in your responses to the Committee's pre-hearing questionnaire that FEMA did, in fact,**

subsequently compete work in the second year of the contracts, resulting in a 73-percent reduction in costs.

a. How do you intend to promote competition, not only in emergency responses to hurricanes, but also throughout the range of contracts FEMA awards?

ANSWER: FEMA intends to increase its already aggressive course in promoting competition. The charts below reflect FEMA competitive contracting data for FY 06 and FY 07 by number of actions and dollars.

Contracting Actions	Base	Competitive Actions	Percentage
FY 06	11,476	6,197	54%
FY 07	7,855	4,006	51%

Contract Dollars	Base	Competitive Dollars	Percentage
FY 06	6.9B	2.4B	35%
FY 07	1.4B	1.1B	81%

*Note: FY 06 reflects post-Katrina contracting activity. FY 07 information has been updated to reflect year end data.

Through this data, FEMA efforts show clear results in its desire to increase competed actions, especially in the percentages. While the number of competitive actions are decreasing in both number and percentage, this is due to the lack of disaster and emergency related activities, and the success of previously competed work.

The Agency's desire to increase competitiveness and decrease costs can be seen in its handling of the Maintenance and Deactivation Contracts (MDCs), which were re-competed and saved FEMA a significant amount of money. With the significant decrease in the temporary housing units, FEMA determined that the majority of its original Mississippi MD contractors were performing well and could support the remaining requirements; however, revised pricing was required and needed to be reevaluated. Therefore, FEMA re-competed the first option period to prepare for this second year of performance. The execution of the Task Order Proposal Request (TOPR) process on the MDCs in Mississippi represents a projected savings of $2.24M for the 12 month follow-on period in the areas of temporary housing maintenance and deactivation. Additional savings may be realized around the execution of emergency maintenance, relocations, repositions, and emergency deactivations. Five contractors were selected to continue services in Mississippi. Currently, there are 13,791 emergency housing units requiring services and all five contractors can compete on any new requirements.

Similar to the MDCs, the Agency decided to re-compete the group site maintenance (GSM) contractors. The original number of sites was 40, and currently 28 sites require

services. FEMA determined that its GSM contractors had performed favorably during the base period and could support the remaining requirements, but once again revised pricing was needed combined with reevaluation for the remaining sites in order to achieve more reasonable pricing in the re-competition. Two contractors were chosen to continue performing services as a result of the re-competition, achieving a 73 percent overall reduction in price. More specifically, this is a cost avoidance of nearly $9.5 million out of a possible total cost of over $12.1 million.

In order to further the efficacy of competitive process, FEMA has addressed one of the key issues that had prevented certain levels of efficiency from being achieved, which was low levels of staffing. At the time of Katrina, OAM had only 35 staff members in its acquisition office and employment slowly increased despite the increased need for more contracting staff; nonetheless, the Agency obligated $6.8 billion in obligated funds and over 10,500 contract actions in FY06. FEMA now has 166 staff members, with 118 being 1102-contract specialist positions. Disaster Assistance Employees (COREs and DAEs) and contractors also provide support along with 747 COTRs throughout organization.

b. In cases in which FEMA is unable to make effective use of competition, what steps will you take to ensure that FEMA does not pay contractors far more than necessary to get the work done?

ANSWER: While immediate response requirements must often be met by the use of acquisition regulations that allow for contracts to be awarded to a single source based on the urgent and compelling nature of the work, FEMA is actively pursuing an approach to increasing competition. First, the Agency is competitively awarding pre-positioned contracts for strategic services and supplies to support response efforts. Additionally, when contracts are awarded to a single source on the basis of urgency or compelling rationale, such contracts are intended to be short-term in nature and prescribe that the services will be transitioned to a subsequent, competitively awarded contract. This is especially true in instances where the recovery effort will be protracted and require on-going support.

5. On December 11, 2007, an article ran in the Gambit Weekly[1] regarding fires in FEMA trailers related to propane explosions.

a. How many deaths has FEMA recorded as being linked to fires in FEMA trailers?

ANSWER: In Louisiana, there have been 91 reported fires. Of these fires, eight (8) deaths occurred in which propane was involved. Five other deaths occurred from fires caused by other sources such as smoking.

In Texas, one death has been linked to a fire in a FEMA trailer caused by a cigarette.

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[1] Matt Robinson, *Up In Flames*, Gambit Weekly, Dec. 11, 2007, *available at* http://www.bestofneworleans.com/dispatch/current/news_feat.php

In Mississippi, there have been no recorded deaths due to fires in FEMA trailers.

In Alabama, there have been no recorded deaths due to fires in FEMA trailers.

b. Are all FEMA trailer contractors properly certified and have proper permits to work on propane systems? If so, when were such certifications or permits obtained? If not, why not?

ANSWER: The MDCs as well as the Individual Assistance – Technical Assistance Contracts (IA-TACs) require that the Contractor furnish all necessary labor, tools, equipment, and materials to perform temporary housing unit maintenance services. The contractor must also obtain all appropriate permits and licenses needed to fulfill the tasks of this contract, including performance on propane systems. Further, the contractor must use certified and licensed personnel to perform the work needed (i.e. plumber, electrician, heating and air). The contracts also require that such permits be provided to the government in order for the contractor to be authorized to perform. Most recently these permits were provided by the MDCs so that they can perform the lease-in activity associated with hauling and installing the housing units.

c. What measures has FEMA taken to address the safety issues raised in the article?

ANSWER: FEMA has taken many measures to address fire safety issues in temporary housing units. FEMA Gulf Coast Recovery Office has hired a Fire Safety Specialist as part of its Safety staff to coordinate with state and local fire safety officials. FEMA has distributed numerous fire safety brochures have been created and distributed to every travel trailer occupant.

When FEMA learned that a number of fire incidents resulted from occupants inadvertently leaving gas jet knobs on and then turning the igniter knob, FEMA changed the color and texture of the igniter knobs to differentiate them from the gas jet knobs. As a result of this outreach, the number of fire incidents declined significantly.

FEMA began working with fire departments to obtain available information used to track the causes of travel trailer fires. Fire investigation reports have been collected from every fire that occurred and FEMA has worked with other agencies and offices to look for trends in order to determine if there were any systemic problems that related to fires in trailers that could be corrected. We also encouraged the involvement of the Louisiana Liquefied Gas Association investigators to do an independent assessment of every suspicious fire in the state to determine if the gas system was at fault for fires.

FEMA also engaged the Public Information Officer with the New Orleans Fire Department to assist with public service spots on local stations explaining safety and fire

prevention measures in which the public could prevent fires. The State Fire Marshall's office also agreed to do similar public service spots and be interviewed by local media outlets explaining the real causes of fires in trailers.

FEMA has contacted the manufacturers of travel trailers in order to try to find measures that could be employed to help prevent fires. In working with some manufacturers, we developed and produced warning stickers explaining safety measures for fire prevention and propane safety and affixed them to all travel trailers.

Senator Daniel K. Akaka
Additional Questions for the Record
Nomination Hearing of Harvey E. Johnson, Jr.
December 12, 2007

1. **During your confirmation hearing, you mentioned that, after your discovery that no members of the press were present at the October 23, 2007 briefing on the California wildfires, you had a member of the media come to FEMA to do a media ethics briefing. Has FEMA provided a more broad ethics briefing to FEMA employees as a result of the incident?**

ANSWER: Yes. On December 6th, the Public Relations Society of America, the preeminent association of Public Relations professionals, conducted a session on ethics in public relations. This session was for all of the HQ and Regional Public Affairs staff, and was widely attended. As well, this will not be the end of our effort to invest more in our employees, we are going to offer and support additional professional development opportunities for all of our employees.

Senator Mary Landrieu
Additional Questions for the Record
Nomination Hearing of Harvey E. Johnson, Jr.
December 12, 2007

1. **If confirmed to be Deputy Administrator of FEMA, how do you plan to be an agent of change?**

ANSWER: I believe that my tenure at FEMA demonstrates a commitment to change, based upon lessons learned, quality analysis, and the encouragement to adopt best practices. Working with Administrator Paulison, we have set a Vision for New FEMA that charts a course to becoming the Nation's preeminent emergency management and preparedness agency. The Vision has guided the significant improvements FEMA has already made in disaster operations, disaster assistance, logistics and all our other core business processes. Pursuit of the Vision, however, is a multi-year effort of continuous improvement, and I am committed to leading that effort with Administrator Paulison. Our initial efforts are focused on building a sustainable organizational structure in Headquarters and the Regions, selecting and supporting quality leaders, instituting standard business processes supported by measures and metrics, and strengthening partnerships across all levels of government, with non-governmental organizations, the private sector and individuals whom we serve. As we move ahead to make further improvements, we will be supported by three key elements: a dedicated FEMA workforce, a supportive Congress that provides the resources and legislative tools we need as well as constructive oversight, and an operational focused President and Secretary who have requested the resources we need and demonstrated support for the efforts we are undertaking to attain the Vision for New FEMA.

2. **Will you commit to do everything you can and to the fullest extent of FEMA's authorities to provide for disaster survivors?**

ANSWER: Yes. Within the vision for New FEMA, one element is to develop, as a core-competency, the non-bureaucratic delivery of disaster assistance to disaster victims and communities. FEMA will be undertaking a number of initiatives to strengthen this new competency.

3. **Will you commit to come to Congress in the event that FEMA's current authorities are inadequate to meet the challenges of a particular disaster or catastrophe?**

ANSWER: Yes. While I believe the Stafford Act provides tremendous flexibility to the President, the Secretary and the Administrator to provide needed resources quickly, like all things I agree it can be improved. I know that our staffs are already working together closely on a number of issues, and I welcome the opportunity to work with you and this Committee to implement changes as necessary.

4. **After FEMA's fake press conference on October 23, 2007, why should the Senate, and more importantly, the American people trust your judgement during future disasters?**

ANSWER: During the confirmation hearing, I had an opportunity to outline for the Committee, and the American public, details of my nearly 40 years of public service. I briefly discussed my background as a Coast Guard officer, and my rise from ensign to Vice Admiral. I briefly highlighted my postings and responsibilities, from junior officer on a Cutter to Commander of both the Coast Guard's largest, and most active mission areas. During my tenure at FEMA, I believe that I have served honorably and faithfully the trust that has been placed in me to enact David Paulison's and my vision for a "New FEMA." I trust that the Senate, and the American people you represent, will make a decision about my judgment based on the totality of my career, and not one regrettable incident for which I have apologized and already taken corrective action to prevent another future occurrence.

5. **How will you ensure that what took place on October 23, 2008 never happens again at FEMA?**

ANSWER: FEMA has already taken corrective action to address what we all acknowledge was a mistake. We have issued Standard Operating Procedures for press events that require advance notice, open conference call lines and that all questioners identify themselves when asking questions. We are also providing additional training in media ethics, including a recent half-day seminar with the Public Relations Society of America.

6. **One of the lessons taken from Hurricanes Katrina and Rita is that the Stafford Act is simply not designed for catastrophes – it is a law that provides resources for disasters that: 1) are limited in geographic size; 2) do not cause a large numbers of evacuations; 3) do not require the rebuilding of large numbers of public infrastructure; and 4) do not require the displacement of individuals for periods of time greater than 18 months.**

    a. **Do you agree that Hurricanes Katrina and Rita exceeded the resources provided to the federal government by the Stafford Act? If so, how should the Stafford Act be changed to more appropriately handle Hurricane Katrina and Rita sized events?**

ANSWER: Hurricane's Katrina and Rita were challenges for all levels of government from both a response and a recovery perspective. It is important to note that the nature of the Stafford Act provides great flexibility for the major recovery programs, but the scope of some of the issues raised by this disaster do not fall neatly into the parameters of the Stafford Act or the mission of FEMA. For example, long term housing issues are best addressed outside of the Stafford Act and FEMA by other Federal agencies like the Department of Housing and Urban Development and we are taking active steps to address them. The larger issue is not that resources were not available, but that we must strive to better employ the extensive resources that exist. We are working purposefully within FEMA and across the interagency community with our state partners and the private sector to address those resource employment issues through the re-write of the National Response Framework, the development of the nationwide Gap Analysis planning effort and the multi-modal evacuation and logistics planning we have undertaken in the gulf. We have also developed better catastrophic planning efforts for many other significant potential

events such as the New Madrid Seismic Zone and the Lake Okeechobee planning to name just a few.

b. Do you believe that the Stafford Act should distinguish between major disasters and catastrophes, as it distinguishes between emergencies and major disasters?

ANSWER: At this time I do not believe such a distinction is warranted but do believe that our planning and review of potential improvements to the Stafford Act should consider the implications of such a change. A Declaration of Major Disaster, by its very definition, allows FEMA and the department to bring the full support of the entire Federal government to bear on a disaster, regardless of size. It is our challenge to work closely with the states to identify in advance of and during an event what the needs are and the best way to provide them in a rapid and non-bureaucratic manor. I commit to working to continually improve that effort.

c. Do you believe that an expanded and more flexible set of utilities should be provided to the federal government during catastrophes?

ANSWER: We are reviewing what additional capabilities we should be developing at the Federal level and encouraging the development of greater capabilities at the state and local level. The National Preparedness Guidelines just approved by the President provide a tremendous framework to build those flexible and nimble capabilities. We look forward to working with the Congress to implement the many changes that are underway to improve our capacity to respond to a catastrophic event and the other emergencies we face as a nation.

7. When will FEMA allow CDC to resume the trailer testing and what is the altered timeline for the completion of each phase of FEMA's testing and analysis of potential health impacts of formaldehyde exposure?

ANSWER: In August 2007, FEMA and the Centers for Disease Control and Prevention (CDC) entered into an Inter-Agency Agreement (IAA) to initiate and complete testing and to provide technical assistance and Public Health Guidance to FEMA to evaluate the indoor environmental air quality in temporary housing units and the associated health effects to residents. CDC is responsible to conduct three concurrent tests: observed formaldehyde in occupied units, health effects on children, and mitigation strategies for unoccupied units.

CDC awarded a contract on December 11, 2007 to a commercial firm specializing in industrial hygiene and air quality measurement. The terms of the contract give them 10 days to prepare for testing and then 35 days to arrange volunteer participation and take the 500 samples of occupied housing units. The report of final results of this study is due in early February 2008. Following the release of the report, joint CDC and FEMA teams will provide consultation with the 500 participant households to discuss the implications of the specific unit results. Based on the results of those consultations, CDC will decide if it is appropriate to extrapolate those results to the remaining temporary housing occupants.

CDC will also assess the Long Term Health Effects on Children. This assessment has already begun with a record review of clinical visits in the Gulf Region. This is a long term study and will take about a year to receive the preliminary results.

The third assessment is a review of mitigation strategies for reducing formaldehyde levels in recreational vehicles, especially travel trailers. The early review and testing has indicated that there is no simple, "off the shelf" technology such as a filter or air purifier that eliminates formaldehyde without producing another similarly irritating substance or produces some other negative effect in the trailer. The final report for this third assessment is due in the Spring of 2008.

8. Will the hotel and motel program for formaldehyde exposure be extended indefinitely as a result of the delay in testing?

ANSWER: The Emergency Lodging Assistance for Occupants in Direct Housing Disaster Specific Guidance (DSG) was put into place for moving applicants out of Temporary Housing Units who expressed concerns regarding formaldehyde and placing them in a hotel/motel for 30 day intervals. This DSG will remain in place until it is reviewed again in August of 2008.

9. What contingencies are being made for the provision of disaster housing in the event of a disaster in the coming months now that the trailer program has been suspended indefinitely?

ANSWER: While the use of travel trailers and park models has been suspended, direct housing is still an available resource. In addition to the existing inventory of new manufactured (mobile) homes, we have efforts underway to procure additional units with specifications modified to drastically reduce the risks of formaldehyde and mold. FEMA has also established a Joint Housing Solution Group which has evaluated over 125 potential disaster housing options, and alternatives to travel trailers and manufactured homes. FEMA continues to identify additional approaches to exhaust prior to the use of temporary housing units, such as the development of a Housing Portal to identify available rental resources, relocation assistance and other additional PKEMRA authorities, and coordination with partner programs identified in the National Disaster Housing Strategy.

10. When will the National Disaster Housing Strategy be completed and released?

ANSWER: The National Disaster Housing Strategy will be completed this winter. This document required the concurrence of partner agencies and entities, and is currently under final review by FEMA.

11. What evidence prompted FEMA to prohibit its employees from entering trailers for fear of safety concerns associated with formaldehyde exposure? How does this exposure and its potential associated health risks differ from the potential health risks to families living in the same type of trailer for an extended amount of time?

ANSWER: Every workplace in the United States is subject to Occupational Safety and Health Administration (OSHA) regulations and FEMA is no different. The FEMA Office of Safety and Health is charged with reviewing occupational practices of our employees and ensuring compliance with all applicable safety regulations. Formaldehyde in the workplace is regulated through OSHA requirements promulgated in 29 CFR 1910.1048.

During the course of our review of internal work practices, the Office of Safety and Health contracted with the Department of Health and Human Services (HHS) Office of Federal Occupational Health (FOH) to monitor formaldehyde exposure during the course of a typical eight hour day in a variety of occupational settings. FOH found a distinct difference between the exposure levels of employees entering occupied units that are typically subject to occupant access, ventilation and temperature moderation and units that are at staging areas where they are sealed for extended periods. It is the "staged units" that are the subject of the employee restrictions, and those may be entered, but only following a prescribed protocol for ventilation.

12. What plans are in place to remove all of the Gulf Coast residents from trailers?

ANSWER: The FEMA Gulf Coast Recovery Office developed a formal housing strategy in early 2007 to ensure an aggressive approach to transitioning occupants to more suitable long term housing and closing travel trailer sites. Each Transitional Recovery Office (TRO) has developed and implemented action plans to move occupants out of Temporary Housing units and into alternate housing solutions. The action plans are based on priorities focusing first on applicants with formaldehyde concerns, then group and commercial sites, and finally working with applicants on private sites who are rebuilding their damaged homes. TRO staff are actively working with each family to assist them with their long term housing needs. Housing, specifically the transition of families from temporary housing units to more permanent housing alternatives, is the number 1 priority for the TROs.

Affordable housing, particularly rental units, is limited in many areas along the Gulf Coast. However, FEMA has taken steps to increase the amount of available rental units and reduce the other barriers (security deposits, damage deposits, background check fees) that may slow the process for an applicant. FEMA redefined the current Corporate Lodging Consultants (CLC) contract on August 24, 2007 to improve landlord participation and the universe of rental properties by expanding lease provisions to include security deposits, cost of damages and application or background check fees. As more rental resources come available, FEMA will be able to continue to move applicants out of temporary housing units throughout the Gulf Coast.

Each TRO has set specific closure dates for group and commercial sites. FEMA is actively working with each applicant in these sites to relocate them from temporary housing units and into more permanent, long-term housing. The Gulf Coast goal is to be completed with the direct housing (travel trailers, park models and mobile homes) mission by December 31, 2008. However, the President did extend the housing program until March 2009; therefore, applicants moved from direct housing units and into rental resources will continue to be assisted until the program ends. FEMA is currently in the process of transitioning applicants receiving rental

assistance to the Department of Housing and Urban Development Disaster Housing Assistance Program.

FEMA and the Centers for Disease Control and Prevention (CDC) announced that testing for formaldehyde levels in trailers and mobile homes will begin Friday, December 21, 2007. CDC will begin indoor air sampling of 500 randomly selected units to determine formaldehyde levels inside a representative sample of occupied trailers and mobile homes purchased by FEMA to provide temporary housing for Gulf Coast residents. CDC will provide guidance to FEMA and information to trailer residents based on scientific findings.

Senator Jon Tester
Additional Questions for the Record
Nomination Hearing of Harvey E. Johnson, Jr.
December 12, 2007

In 2006, FEMA issued 15 contracts to maintain or deactivate housing units in the Hurricane Katrina recovery area. In auditing these activities, the non-partisan Government Accountability Office found that "FEMA's ineffective management resulted in about $30 million in wasteful and improper or potentially fraudulent payments to the contractors from June 2006 through January 2007 and likely led to millions more in unnecessary spending beyond this period." During this same time period, FEMA also obtained the use of a former Army base in Anniston, Alabama, as housing for as many as 1,000 evacuees. Despite spending $8 million to refurbish the facility, it was closed just two months later.

a). Please comment on how these poor acquisition decisions occurred and what steps FEMA has taken to prevent similar decisions in the future.

Answer to issue of $30 million in waste and fraud identified in GAO report 08-106:

ANSWER: The 15 contracts referenced in GAO report 08-106 refer to the ten (10) Maintenance and Deactivation contracts (MDCs) and the five (5) Group Site Maintenance contracts (GSMCs) for housing units in Mississippi. The MDCs and GSMCs were awarded in April and November of 2006, respectively.

The MDC and GSMC requirements were originally being met by the four large Individual Assistance Technical Assistance contracts (IA-TAC I) issued non-competitively to Fluor, Shaw, CH2M Hill, and Bechtel. These IA-TAC I contracts were awarded non-competitively to the four companies due to urgent circumstances and a need to quickly execute a housing mission of unprecedented scale. Once the situation in the Gulf was initially stabilized and the majority of initial requirements were in place, FEMA's goal was to award parts of the IA-TAC I work to small and small disadvantaged businesses and local firms.

The $30 million in wasteful and potentially improper payments referenced in the GAO report refers to the ten MDCs and is broken down into two separate areas: 1) Improper allocation of work among the ten selected contractors and 2) Approval of unsupported work and/or undocumented invoices.

1. Improper allocation of work among the contractors

Background
FEMA established and issued two solicitations for each state including Mississippi; one solicitation was for small businesses and the other was for 8(a) firms. As a result of the

outreach efforts and interest in the solicitations among industry partners, FEMA received 258 proposals from interested vendors. The Agency subsequently reviewed and evaluated all 258 proposals and determined 166 of them were technically acceptable and should be evaluated for price reasonableness.

Price analysis was conducted on each of the technically acceptable proposals utilizing historical data. Due to the high number of proposals received, contractors were selected based on analysis of their overall proposed set of services (37 separate contract line items for discrete services in the first year; including such services as monthly preventative maintenance, contractor phase-ins, deactivations, emergency after-hours repairs, and septic cleaning services). Prior trends were utilized to weight certain line items more heavily and to predict their usage. Proposals were not evaluated by independently assessing the proposed price for each service requirement or line item; and the reasonableness of the contract prices cannot be meaningfully evaluated on the basis of a single line item. Additionally, FEMA utilized the Defense Contract Audit Agency (DCAA) to evaluate the firms' ability to perform.

FEMA recognizes there was some risk associated with its price analysis methodology; however, in order to meet its objectives of stimulating economic growth after the storm and efficiently transitioning from large business non-competitive contracts to competitively-awarded small business contracts, accepting a certain amount of risk was appropriate. It was the best decision the Agency could make at that time.

Issue in GAO report
GAO's report criticized FEMA for improperly allocating work to contractors somewhat evenly throughout the state instead of giving the majority of work to the least expensive contractors. GAO argued that by giving the majority of work to the contractors with the least expensive services for the most-heavily utilized services, FEMA could have saved approximately $16 million.

FEMA considerations in work allocation
FEMA considered costs in its work allocation decision; however, FEMA's analysis was conducted based on historical data and consisted of predictions of how much a particular service line item would be exercised. While the analysis was conducted with educated estimates, it was not possible to completely determine ahead of time what the most costly requirements would be[1]. Also, FEMA wanted to avoid exercising the contract line item for costs of extra mileage used outside of the maximum work radius. By more evenly spreading out the contractors, each contractor was based closer to their assigned units; thereby ensuring that the extra mileage service line item was utilized less and that the small businesses were more capable of servicing units effectively. A more even distribution of work may have led to higher costs, but it mitigated potential performance

[1] While the IA-TAC I contractors were performing the same services as the MDCs (among others), it is difficult to make one-to-one comparisons between the two sets of requirements This is because the IA-TAC I contracts were structured differently and grouped services instead of breaking out the individual services in line items as was the case with the MDCs. For this reason, the IA-TAC I contracts could only serve as a limited guide as to what services would be heavily used with the MDCs

risks which could have resulted in contractors' inability to perform; this potential risk had unpredictable cost impacts.

While it was important to factor costs in the allocation of work, FEMA had other considerations which were important to ensuring the contracts were successful and the housing mission was successfully carried out. As several of the MDC contractors were former subcontractors under the IA-TAC I contracts, FEMA made an effort to allocate units to contractors who were already performing the work. This ensured an effective transition from the IA-TAC I contractors to the MDCs, and minimized the amount of disruption to applicants which resulted when the IA-TAC I contractors ceased performing Maintenance and Deactivation requirements.

In addition, the MDCs were awarded to small businesses and 8(a) firms with a preference to companies local to Mississippi. By awarding units to all each of the selected MDC contractors, FEMA was also able to contribute to the devastated local economy and the disadvantaged business community.

New measures taken
As the first year of performance expired on the MDCs and the number of units requiring service declined, FEMA re-competed the second year task orders for continuing performance among the 10 MDCs. The evaluation criteria in the Task Order Proposal Request (TOPR) included technical and management approach, past performance, and price. The execution of the TOPR process represents a projected savings of $2.24M for the follow-on period in the areas of Maintenance and Deactivation. Additional savings may be realized around the execution of emergency maintenance, relocations, repositions, and emergency deactivations. A similar approach will be utilized for the third year of performance.

2). Approval of unsupported work and/or undocumented invoices.

Issues in GAO report
The analysis and investigation conducted by GAO concluded that FEMA approved and paid invoices for work which may not have occurred because of lack of required back-up documentation. The report estimated that up to $16 million could have been fraudulently invoiced.

New measures taken
FEMA will actively seek to recoup any payments incorrectly made to contractors. The Agency is awaiting Department of Justice and Department of Homeland Security Office of the Inspector General findings on fraudulent payments.

FEMA acknowledges that it did not have an adequate contract oversight structure in place at the time the MDCs were awarded and in the following months. At the time of Hurricane Katrina, FEMA's acquisitions office had approximately 35 people. Employment slowly increased in the following months despite the increased need for more contracting staff; nonetheless, FEMA obligated $6.9 billion in funds and over

11,400 contract actions in FY06. In addition to a shortage of Contracting Officers (COs) to effectively administer these contracts, there was a lack of Contracting Officer Technical Representatives (COTRs) to properly perform day-to-day oversight activities.

In response to the need for more effective oversight on these contracts and others in the Gulf Coast including the GSMCs, FEMA has implemented several initiatives:

1. FEMA's new robust Office of Acquisition Management (OAM) now has 166 PFT positions and 118 of these are 1102-series contract specialist positions. In addition, OAM has temporary FEMA personnel supporting acquisitions at headquarters and the various Total Recovery Offices (TROs) in the Gulf Coast. The number of COTRs overseeing the MD, GSM, and other contracts in the Gulf Coast has more than doubled since January 2007 (the end of GAO's period of analysis).

2. A Program Management Office (PMO) was established in the Gulf Coast Recovery Office (GCRO) which has developed and enforced standardized invoice payment processes across all of the TROs. This PMO has designed and conducted multiple training events across the Gulf Region outlining and providing guidance to COTRs on proper invoicing procedures including courses such as:

   - "What is a proper invoice?"
   - "What constitutes proper documentation for receipt of goods and services?"
   - "How should invoices be reviewed and how can work be confirmed?"
   - "What justifications for partial payments are required?"

   In support of the training effort, Standard Receiving Documents and Justification Forms have been designed and are required for invoices to be processed. Standardized invoice payment processes have improved the invoice approval process and reduced possible human oversight error and made records more available for audit.

   The PMO has also been successful at implementing a standard Quality Assurance Surveillance Plan (QASP) for the MDCs throughout the Gulf Coast to ensure that contractors are effectively complying with the contract terms and conditions and providing high-quality services. The QASP measures timeliness, quality, and customer satisfaction of MDC performance uniformly across the Gulf Coast. Each month, all maintenance, emergency maintenance and deactivation work orders are sampled for each contractor and then evaluated against specific criteria outlined in the QASP. The evaluated work orders are assigned a score. Each monthly score is reviewed with the contractor and guidance is given on how to improve. At the end of each quarter, the sampled work orders are evaluated and based on the scores an incentive or disincentive of anywhere from +15% to -15% of the invoiced

amount is applied to each contractor. The new plan focuses on ensuring timely delivery of quality services to FEMA housing applicants throughout a trailer life cycle.

3. A robust COTR program was developed to ensure higher levels of contract management and oversight. This initiative has been successful and has accomplished the following:

   - Implemented a tiered COTR certification program
   - Shaped the COTR workforce to ensure a higher level of competency and professionalism
   - Complied with Department of Homeland Security (DHS) and Office of Management and Budget (OMB) regulations and policy while leveraging best practices
   - Established a COTR community website

   Through the use of this program and improvement of contract management and oversight, FEMA has subsequently improved its invoice approval and payment process.

4. FEMA has put in place policies and procedures for the use of Contract Administration Plans (CAPs) which are designed to facilitate efficient and effective contract administration. The CAPs outline the required level of contractor performance surveillance, the contract terms and conditions for contract administration, performance milestones, and reporting requirements. FEMA has successfully used a CAP for IA-TAC II for the18 months. Additionally, a CAP was implemented for the New Orleans Amtrak Evacuation Train contract.

   CAPs improve the Agency's post-award contract execution, by providing consistent guidance on ordering, competing, and administering procedures for task orders on task order-type contracts. They also promote task order competition while ensuring that services are available expeditiously to meet critical disaster response needs, and they establish consistent enterprise-wide contract administration processes for the COTRs in various regions.

Answer to Anniston Army Base issue (Starship Facility Renovation Project in Anniston, AL for Hurricane Katrina Evacuees):

ANSWER: FEMA spent approximately $7 million to renovate buildings at the abandoned Fort McClellan military base in Anniston, Alabama, also known as the Starship facility, to provide temporary housing for individuals and families displaced by Hurricane Katrina. The buildings were intended to house up to 600 evacuees, however they attracted fewer than 20 residents before their use was discontinued on October 25, 2005.

At the time FEMA decided to proceed with renovations, there was significant involvement by the Office of the Governor of Alabama, as well as the Joint Powers Authority, an unincorporated non-profit organization created to redevelop Fort McClellan, in identifying the availability of the Starship facility.

One of FEMA's top priorities following Katrina was to find shelter for hundreds of thousands of displaced evacuees. To meet that priority, FEMA Field staff was given wide latitude to aggressively and quickly locate and prepare facilities across the Gulf Coast to accommodate the displaced populations. In support of this urgent humanitarian mission, the renovation of the Starship facility was designed to provide a much-needed shelter resource at a time when existing congregate shelter facilities in the affected area were literally overflowing with evacuees. However, the anticipated demand for the Starship facility as a shelter failed to materialize as expected. The facility was still uninhabitable when the majority of evacuees arrived in Alabama – repair work was only partially complete at that time.

As a result of a review of the Starship facility renovation project, the DHS Inspector General made three recommendations to FEMA. First, the Inspector General recommended that FEMA explore legal avenues to recover FEMA's investment in the facility. In response, FEMA found that there is no legal recourse against the contractor for the project, as the contractor performed as directed by the government.

Second, the Inspector General recommended that FEMA strengthen its management structure over alternative housing for disaster victims and require that housing officials determine that facilities will be acceptable to evacuees before acquiring them. However, the Starship facility was never intended to provide an alternative *housing* solution, but a *shelter* solution. FEMA successfully sheltered thousands of evacuees in safe and sanitary conditions by quickly initiating a hotel/motel program and other forms of interim sheltering. For these projects Agency personnel followed established chains of command and protocols. In the case of the Starship renovation, well-intentioned efforts to quickly accommodate the anticipated influx of an extraordinarily large number of evacuees required difficult but quick decisions, and required staff to expedite normal processes. FEMA has developed and published a Mass Sheltering and Housing Assistance Strategy, which outlines how FEMA will manage transitional sheltering operations in the future, if faced with a similar disaster situation.

Third, the Inspector General recommended that FEMA require that housing decisions be approved in writing and coordinated with field and headquarters recovery managers. While, again, this was a sheltering operation, not a housing operation, conducted under the Emergency Protective Measures authority of Section 403 of the Stafford Act, which generally do not require headquarters review and approval prior to implementation, in order to help avert future commitments such as this, FEMA is institutionalizing guidance on emergency shelter development projects. Insofar as housing operations are concerned, FEMA requires a housing plan for every housing operation. FEMA recognizes the necessity for formalizing this planning process and is ensuring that appropriate protocols

for submitting and authorizing sheltering plans are outlined in the Emergency Support Function 6 (ESF-6) Standard Operating Procedure.

b). In your view, are such procurement and contract oversight responsibilities clearly delineated in documents such as the National Response Plan? If not, what changes do you recommend?

ANSWER: FEMA policy, as reflected in the National Response Plan (NRP) and its soon-to-be-issued replacement, the National Response Framework (NRF), requires that FEMA disaster operations be organized and managed based on the National Incident Management System/Incident Command System (NIMS/ICS) model. This model specifies the contracting function as a key component of the Administration and Finance Section. NIMS/ICS also includes extensive guidance concerning resource management. Additionally, contracting and procurement issues are addressed in Emergency Support Function 7 (ESF 7), Logistics Management and Resource Support.

The new NRF encourages governments at all levels to conduct Advanced Readiness Contracting. Advanced Readiness Contracting ensures that contracts are in place before an incident for commonly needed commodities and services such as ice, water, plastic sheeting, temporary power, and debris removal. This type of contracting improves the Federal Government's ability to secure supplies and services by streamlining the process of ordering, acquiring, and distributing resources when needed.

The NRF also encourages Federal departments and agencies to execute pre-scripted mission assignments (PSMAs) and readiness contracts, as directed by DHS. In 2006, FEMA only had a total of 44 PSMAs in place for support. By June 15, 2007, FEMA completed an additional 146 PSMAs with ESF partners and now has 190 PSMAs. Of the 190 PSMAs, there are 174 for Federal Operations Support, four for Technical Assistance, and 12 for Direct Federal Assistance. Theses PSMAs provide support in areas such as rotary wing heavy and medium airlift, tactical and strategic transportation, communications, emergency route clearance, aerial damage assessment, preparation of housing sites, support for mobilization centers and operational staging areas, fuel distribution support, security and public affairs support, and medical evacuation and facility support. There are currently up to 30 additional PSMAs under review.

Prior to Hurricane Katrina, FEMA's Acquisition office had approximately nine (9) pre-positioned contracts in place for disaster response. As of November 2007, OAM has approximately 27 pre-positioned response contracts and 70 pre-positioned recovery contracts in place for use in the event of a disaster. Pre-positioned contracts are negotiated and awarded prior to disasters and ensure the right supplies and services are provided at the right time with a fair and reasonable price. OAM utilizes extensive market research, negotiation, and competition to award these contracts. The contracts are for those types of goods and services that are traditionally utilized in a disaster and/or not fully provided by State and local governments. By putting these contracts in place before a disaster, these pre-positioned contracts ensure competitiveness and price reasonableness; it allows for a more responsive industry focus enabling quick mobilization of resources. The use of them has resulted in a significant reduction of urgent and compelling contracting procedures but also ensures that the right products and services are deployed in a timely manner.

STATEMENT FOR THE RECORD

JEFFREY W. RUNGE, M.D.

ACTING ASSISTANT SECRETARY FOR HEALTH AFFAIRS
AND CHIEF MEDICAL OFFICER
UNITED STATES DEPARTMENT OF HOMELAND SECURITY

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

DECEMBER 12, 2007
NOMINATION HEARING

Good morning Mr. Chairman, Ranking Member Collins and distinguished Members of the Committee. It is my privilege to appear before the Committee today as the President's nominee to become the first Assistant Secretary for Health Affairs and Chief Medical Officer of the Department of Homeland Security. I want to thank my friend Senator Burr for his warm introduction. I also want to thank President Bush and Secretary Michael Chertoff for this opportunity.

Our Nation has always faced threats to its citizens, be they natural events or acts of aggression by individuals, groups or foreign states. But the events of the last six years within our homeland have spurred many people like me to action, who might otherwise have been content to stay comfortably in a profession in the private sector. I have been fortunate to be part of our young Department's start up and maturation, to witness real leadership and singleness of purpose first hand, and to learn from weathering the storms of a challenging merger and creation of a new culture. I have gained tremendously from having been given the chance to start up a new organization that is so vital to the security of our Nation, and if confirmed, look forward to finishing the task I started 27 months ago.

As part of the Secretary's second stage review of the Department of Homeland Security (DHS) in 2005, I was appointed to be the Department's first Chief Medical Officer, and have served in that capacity since September, 2005. Congress codified the Office of the Chief Medical Officer and responsibilities of the Chief Medical Officer in the Homeland Security Act in October 2006. The responsibilities of the Chief Medical Officer ensure that the Secretary and the FEMA Administrator receive the best possible advice on public health and medical issues in real-time, in preparation for, during, and while recovering from an event. In standing up the office, I have focused on these primary areas:

- Serving as the Department's principal health and medical authority in both a policy and operational capacity;
- Leading the Department's biodefense activities, including policy, strategy, program operations, requirements, and metrics;
- Developing a coordinated national biodefense architecture for WMD planning and catastrophic consequence management; and
- Ensuring that the Department's employees are supported by an effective Occupational Health and Workforce Protection program.

Having worked in the fields of emergency medicine, public health and safety policy throughout my entire career, I have the knowledge and experience to make strong contributions to our young Department and provide the leadership necessary to help protect the security of the homeland. If confirmed, I will continue to work diligently to meet the goals for the Office of Health Affairs.

By way of history, I am a native North Carolinian, where I was a physician, educator, and researcher in emergency medicine. I have spent my life in the field of trauma care and injury prevention, starting as an EMT while in college at the University of the South in 1974, through medical school at the Medical University of South Carolina, and residency in emergency medicine in Charlotte. I practiced and taught emergency medicine at Carolinas Medical Center in Charlotte for 17 years and founded the Carolinas Center for Injury Prevention and Control, driving local and regional programs in prevention, incident management, and response by integrating data from emergency medical care, public safety, and transportation. I had the opportunity to participate actively in the political process by working with local and State officials and the North Carolina General Assembly on many pieces of safety policy and legislation. I regard my experience in injury control at the local, State, and National levels as

practicing applied public health, with the opportunity to positively affect thousands of lives with my work, rather than one at a time as I did in my medical practice.

My service to the Nation from inside the Federal Government began in 2001, when President Bush nominated me to be the 12th Administrator of the National Highway Traffic Safety Administration (NHTSA). I was confirmed by the Senate in August, 2001, and served in that capacity until 2005, having the responsibility for improving safety of our Nation's roadways and regulating the automotive industry. That experience enabled me to respond when Secretary Chertoff asked me to help him address another potential massive public health problem -- the aftermath of an act of terrorism by chemical, biological, or radio-nuclear weapons, and the vulnerability of our Nation's food and water.

I am very proud of my record at NHTSA, where I focused on five priorities: increasing safety belt use, reducing impaired driving, reducing rollover deaths and injuries, improving the crash compatibility of cars and light trucks, and improving NHTSA's data systems. The success we enjoyed was due largely to work done at the local level – by the cop on the beat, the EMS professionals in the street, and the advocate community – supported by science-based programs developed at the National level. By working through a robust NHTSA regional system with communities and private sector partners, we were able to achieve a National safety belt use rate of 82%, the first absolute decrease in highway deaths in a nearly a decade, the largest decrease in the number of alcohol-related fatalities since 1992, stimulating the redesign of SUV's to lower rollover risk, and driving child traffic fatalities to historic lows.

This same approach of using the expertise at the community level to implement science-based interventions is also the key to preparedness for catastrophic incidents. Congress authorized the Chief Medical Officer to serve as the Department's primary point of contact to the

public and the private sector on all medical and public health matters. As our small office grows into one that can fulfill our obligations, my intention is to enable the Office of Health Affairs to achieve a similarly robust regional presence so that we may use the assets of all of DHS, including the FEMA regional professionals, along with the regional resources of the Department of Health and Human Services (HHS), to assure a better state of local preparedness, fully integrating health preparedness among all the sectors. The status of our National preparedness depends heavily upon the status of local readiness, which in turn depends upon unified principals, planning, equipping, training and exercising across various sectors.

The authorizing legislation, P.L. 109-295 (The Post Katrina Emergency Management Reform Act), provided that the Chief Medical Officer serve at the assistant secretary level, be nominated by the President, and confirmed by the Senate. It also reorganized the Department to make FEMA a larger and more robust organization. The Secretary, like Congress, recognized the importance of the Chief Medical Officer's position, used his authority to create the Office of Health Affairs (OHA) to consolidate the Department's biodefense responsibilities, including program operations, planning and incident management for biological events, and to ensure that the Department had policies, programs and metrics in place to protect its workforce through occupation safety and health and tactical medical support. The intent was to create an office with Department-wide and cross-cutting responsibilities. This massive mission was undertaken with a token budget and a very small but very dedicated and tireless staff, deeply devoted to the cause of the health preparedness of the Nation. The OHA began officially on March 31, 2007, and in late June we received permission to reprogram funds to allow us to begin hiring the necessary personnel and securing space and infrastructure support. We are hopeful that we will receive the President's full request in FY 2008, which will allow us to begin to fill the many gaps

that exist in our Nation's biodefense and our service to the Department's components and employees.

Since the reprogramming, we have made significant strides in assembling a deeply talented and dynamic group of public servants, many of whom came out of the private sector into government for lower financial compensation, simply because they understand the urgency of our mission and want to apply their expertise to it. We have been successful in attracting some of the top leaders in their fields, including physicians trained in emergency medicine, EMS, trauma care and occupational health and safety; veterinarians specializing in animal public health and biological threats; PhDs trained in biosurveillance and chemical and biological defense; and professionals with policy and legal expertise. We have attracted some of the Department's best up and coming administrative and management professionals to assure that we have the infrastructure in place to support our program experts. It is my top priority to build a top-notch career workforce that will be here to help protect our Nation with or without political leadership, during times of transition and beyond.

By the end of my tenure, I intend to leave my successor with a well-defined mission, strategic plan, and a budget to support it. I intend to leave behind a fully functioning National Biosurveillance Integration Center (NBIC), a robust Office of Food, Agriculture and Veterinary Defense, and an improved BioWatch early warning program. I intend to leave behind strategic plans to counter and mitigate biological, chemical and radio-nuclear attacks, informing guidance for coordinated health preparedness grants, and the capability of fully supporting the Secretary and the FEMA Administrator during an event of any magnitude. I intend to leave with the assurance that our components are supported with health and safety policies, standards and

metrics for the protection of our workforce and with access to support and advice on all health and medical matters.

Chairman Lieberman and Ranking Member Collins, I would like to thank you again for considering my nomination. Your continued investment in the Office of Health Affairs is critical. I look forward to working with you and your staff on the many issues threatening our Nation's homeland security. It has been a true honor to come to work every day to serve and protect the homeland security of the Nation. Standing up this capability for the Secretary and the country has been one of the greatest challenges of my professional life, and I believe we are headed in the right direction and making tangible progress in our efforts to be better prepared for the threats that America faces. Thank you.

###

REDACTED

BIOGRAPHICAL AND FINANCIAL INFORMATION REQUESTED OF NOMINEES

A. BIOGRAPHICAL INFORMATION

1. **Name:** Jeffrey William Runge, M.D.

2. **Position to which nominated:** Assistant Secretary for Health Affairs, Department of Homeland Security

3. **Date of nomination:** August 2, 2007

4. **Address.**

5. **Date and place of birth:** October 20, 1955, Charlotte, NC

6. **Marital status:** Married to Virginia Deck Runge

7. **Names and ages of children:** Emily Catherine Runge (24), William Edgar Runge (20)

8. **Education:**

Doctor of Medicine Medical University of South Carolina Charleston, South Carolina	1977-1981
Bachelor of Arts The University of the South Sewanee, Tennessee	1973-1977
Emergency Medical Technician Nashville, Tennessee	1974
Middleton High School Charleston, SC	1970-1973

9. **Employment record:**

Assistant Secretary for Health Affairs (Acting) & Chief Medical Officer US Department of Homeland Security	3/2007-Present
Chief Medical Officer, US Department of Homeland Security	2005-Present

Acting Under Secretary for Science & Technology, US Department of Homeland Security	2/2006-8/2006
Administrator, National Highway Traffic Safety Administration, US Department of Transportation	2001-2005
Department of Emergency Medicine, Carolinas Medical Center, Charlotte, NC	
Assistant Chair	1986-2001
Clinical Instructor	1984-1986

10. Government experience (other than above):

Assistant Medical Examiner Mecklenburg County, NC	1998-2001
Medical Fellow National Highway Traffic Safety Administration Washington, DC	1996
Injury Control Grant Review Committee National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC) Atlanta, GA	1995-2001
Traumatic Brain Injury Program Advisory Board Office of Emergency Medical Services for Children Health Services Resource Administration (HRSA)	1998-2001
Audit & Review Committee Mecklenburg County Emergency Medical Services Charlotte, NC	1984-1995
Mecklenburg County Emergency Medical Services Advisory Council Charlotte, NC	1987-1993
NC Governor's Task Force on Driving While Impaired	1998-2000 1994-1995
NC Governor's Task Force for Healthy Carolinians 2010	1999-2000
NC Office of Emergency Medical Services Trauma Systems Task Force	1991-1996
NC Governor's Task Force on Injury Control Co-Chairman	1988-1992

11. Business relationships:

Board of Trustees The University of the South Sewanee, TN	1997-2000
Executive Committee North Carolina Medical Society Raleigh, NC	1996-2001
Secretary, Board of Directors Foundation for Education and Research in Neurological Emergencies Chicago, IL	1998-2001
Board of Directors Association for the Advancement of Automotive Medicine Chicago, IL	1999-2001
Board of Directors North Carolina College of Emergency Physicians Raleigh, NC	1986-1992
Board of Directors Mecklenburg County Medical Society Charlotte, NC	1992-93 & 1996-98
Editorial Board Emergency Medicine Alert Atlanta, GA	1994-1999
Board of Advisors Highway Safety Research Center University of North Carolina Chapel Hill, NC	1999-2001
Board of Advisors NC Safe Kids Raleigh, NC	2000-2001
Consultant Wyeth-Ayerst Resident Reporter Program	1999-2000
Consultant Baxter Pharmaceuticals Hemoglobin Therapeutics Program Chicago, IL	1999

Consultant to the following law firms and insurance companies:

Thompson & Knight Dallas, TX	2000
Womble, Carlisle, Sandrige & Rice Charlotte, NC	2001
Bennett and Guthrie Winston-Salem, NC	2000
Medical Protective Insurance Company Fort Wayne, Indiana	2000

12. Memberships:

American College of Emergency Physicians Dallas, TX	1981-Present
Chairman - Alcohol Screening Task Force	2000-2001
Chairman - Injury Control Section	1994-1995
Councilor	1993-1995
Chairman, Injury Prevention & Control Committee	1992-1993
North Carolina Medical Society Raleigh, NC	1984-Present
Speaker, House of Delegates	1997-2001
Vice-Speaker, House of Delegates	1996-1997
Chairman, Injury Control Committee	1994-1997
Commissioner	1994-1995
Chairman, Disaster & Emergency Care Committee	1992-1994
Chairman, Emergency Medicine Section	1988-1989
Society for Academic Emergency Medicine Lansing, MI	1984-2001
Association for the Advancement of Automotive Medicine Chicago, IL	1990-2001
Executive Committee	2000-2001
Board of Directors	1999-2001
North Carolina College of Emergency Physicians Raleigh, NC	1981-2001
President	1990-1991
Board of Directors	1986-1992
Mecklenburg County Medical Society	1984-Present

Charlotte, NC	
Board of Directors	1996-1998
	1992-1993
Secretary	1993
Chairman, Disaster & Emergency Care Committee	1989-1992
Applied Research Ethics National Association Boston, MA	1989-1994
American Medical Association Chicago, IL	1984-2001
Myers Park Country Club Charlotte, NC	1998-Present

13. Political affiliations and activities:

(a) List all offices with a political party which you have held or any public office for which you have been a candidate.

I have neither held an office with a political party, nor have I been a candidate for public office.

(b) List all memberships and offices held in and services rendered to all political parties or election committees during the last 10 years.

I served on the Board of Directors of the NC Medical Society Political Action Committee from 1991 to 2001, serving as Vice-Chair 1996-1997.

(c) Itemize all political contributions to any individual, campaign organization, political party, political action committee, or similar entity of $50 or more during the past 5 years.

Pat McCrory for Mayor, Charlotte, NC (2003)	**$ 100**
Sue Myrick for Congress (2003)	**$ 250**
Cobey for Governor (2003)	**$ 250**
Bush-Cheney '04 (2004)	**$4,000**
Richard Burr for Senate (2004)	**$ 500**
Sue Myrick for Congress (2006)	**$ 250**
Joe Lieberman for Senate (2006)	**$ 500**
Mike DeWine for Senate (2006)	**$ 500**

14. Honors and awards:

"Flame of Life" Award, National Safety Council, 2006

2006 Distinguished Alumnus, Medical University of South Carolina, Charleston, SC

2004 Distinguished Alumnus, The University of the South, Sewanee, TN

Director's Corporate Award: "To Promote and Protect the Public's Health," Mecklenburg County Health Department, 2001

George Podgorny Emergency Medicine Service Award. NC College of Emergency Physicians, 1997.

Highway Safety Leadership Award, NC Governor's Highway Safety Program, National Highway Traffic Safety Administration, 1996

Best Oral Methodology Research Presentation, Society for Academic Emergency Medicine, 1992

Phi Beta Kappa, The University of the South

Omicron Delta Kappa, The University of the South

Georgia M. Wilkins Scholarship (Academics, Leadership, Service), The University of The South, 1973-77

Charles Pollard Marks Scholarship (Outstanding Junior in the College), The University of the South, 1976-77

Hoff Scholarship (Chemistry), The University of the South, 1974-75

Sullivan Scholarship (Academics), The University of the South, 1976-77

15. Published writings:

Peer-Reviewed Manuscripts

Durbin DR, **Runge JW**, Mackay M, Meissner U, Pedder J, Wodzin E, Yoganandan N. Booster seats for children: closing the gap between science and public policy in the United States. *Traffic Inj Prev* 2003; 4(1): 5-8.

Silverman RA, Osborn H, **Runge JW**, et al. IV magnesium sulfate in the treatment of acute severe asthma: a multicenter randomized controlled trial. *Chest* 2002; 122:489-497.

Moran GJ, Talan DA, Mower W, Newdow M, Ong S, Nakase JY, Pinner RW, Childs JE,

for **the Emergency ID Net Study Group**. Appropriateness of Rabies Post-exposure Prophylaxis Treatment for Animal Exposures. JAMA 2000; 284: 1001-1007.

Talan DA, Moran GJ, Newdow M, Ong S, Mower WR, Nakase JY, Pinner RW, Slutsker L, for the **Emergency ID NET Study Group**. Etiology of Bloody Diarrhea Among Patients Presenting to United States Emergency Departments: Prevalence of E. coli 0157:H7 and Other Enteropathogens. *Clin. Infect. Dis.* 2000 (in press).

Sloan EP, Koenigsberg M, Houghton J, Gens D, Cippolle M, **Runge JW**, Mallory MN, Rodman G, for the DCLHb Traumatic Hemorrhagic Shock Study Group. The informed consent process and the use of exception to informed consent in the clinical trial of DCLHb in severe traumatic hemorrhagic shock. *Acad Emerg Med* 1999; 6(12):1203-1209

Sloan EP, Koenigsberg M, Gens D, Cippolle M, **Runge JW**, Mallory MN, Rodman G, for the DCLHb Traumatic Hemorrhagic Shock Study Group. Diaspirin cross-linked hemoglobin (DCLHb) in the treatment of severe traumatic hemorrhagic shock: a randomized controlled efficacy trial. *JAMA* 1999; 282(19): 1857-1864.

Peterson TD, Jolly, BT, **Runge JW**, Hunt RC. Motor vehicle safety: current concepts and challenges for emergency physicians. *Ann Emerg Med* 1999; 34(3):384-393.

Talan DA, Citron DM, Abrahamian FM, Moran GJ, Goldstein EJC, for the **Emergency Medicine Animal Bite Infection Study Group**. Bacteriologic analysis of infected dog and cat bites. *NEJM* 1999; 340(2): 85-92.

Talan DA, Moran GJ, Mower WR, Newdow M, Ong S, Slutsker L, Jarvis WR, Conn L, Pinner RW, for the **Emergency ID NET Study Group**. Emerg ID Net: An Emergency department based emerging infections sentinel network. *Ann Emerg Med* 1998;32(6):703-711.

Biros MH, **Runge JW**, Lewis RJ, Doherty C. Emergency medicine and the development of the Food and Drug Administration's final rule on informed consent and waiver of informed consent in emergency research circumstances.
Acad Emerg Med 1998; 5:359-368.

Sweeney TA, **Runge JW**, Gibbs MA, Raymond JC, Schafermeyer RW, Norton J. Automatic external defibrillators in an urban EMS system.
Ann Emerg Med 1998; 31(2): 234-240.

Madden C, Garrett JM, Cole TB, **Runge JW**, Porter CQ. The urban epidemiology of recurrent injury: beyond age, race, and gender stereotypes.
Acad Emerg Med 1997; 4(8):772-775

Young B, **Runge JW**, Waxman KS, Harrington T, Wilberger J, Muizelaar JP, Boddy A, Kupiec JW. Effects of Pegorgotein on Neurologic Outcome of Patients with Severe Head Injury: A Multicenter, Randomized Controlled Trial. *JAMA* 1996;276(7):538-543

Runge JW, Pulliam CL, Carter JL, Thomason MH. Enforcement of Drunken Driving Laws in Cases Involving Injured Intoxicated Drivers. *Ann Emerg Med* 1996; 27:66-72

Biros MH, Lewis RL, Olson CM, **Runge JW**, Cummins RO, Fost N: Informed Consent in Emergency Research. *JAMA* 1995; 273(16):1283-1287

Fligner DJ, Spivey WH, **Runge JW**. Informed Consent and the Regulation of Research *(SAEM Position Paper) Academic Emerg Med* 1994; 1(6):561-562

Runge JW, Martinez JC, Caravati EM, Williamson SG, Hartsell SC. Histamine antagonists in the treatment of acute allergic reactions. *Ann Emerg Med* 1992; 21(3):237-241.

Ribbeck BM, **Runge JW**, Thomason MT, Baker JW. Injury surveillance: a method for recording E codes in injured emergency department patients. *Ann Emerg Med* 1992; 21(1):37-40

Vaughn DE, **Runge JW**. Out-of-hospital do not resuscitate orders in North Carolina. *NC Med J* 1991; 52(9): 433-435.

Caravati EM, **Runge JW**, Hartsell SE. Nifedipine in renal colic: a double-blind crossover placebo controlled clinical trial. *Ann Emerg Med* 1989; 18:352-54

Reviews and Chapters:

Runge JW. Motor vehicle crash biomechanics: Interpreting the Polaroid. *Emergency Medicine Alert* 2000; 6(8): 61-63.

Runge JW. Airbags and crash injury: effectiveness and risk. *Emergency Medicine Alert* 1998;4(9):69-71.

Runge JW, Hargarten S. Injury Control. In *Emergency Medicine: Concepts and Clinical Practice, Fourth Edition*. Rosen, Barkin, et al, Ed. St. Louis, MO. 1997
1996

Runge JW, Allen FH. Emergency Treatment of Status Epilepticus. *Neurology* 1996; 46(6):S20-S23

Runge JW. Treatment of status epilepticus. *Emergency Medicine Alert* 1996;3(4):28-30

Runge JW. Status epilepticus: a neurologic emergency. *Emergency Medicine Alert* 1996;3(3):21-23

Runge JW. Emergency research: the problem with informed consent. *Emergency Medicine Alert* 1995; 2(5):37-39

Kline JA, **Runge JW**. Streptococcal Pharyngitis: A Review of Pathophysiology, Diagnosis, and Management. *J Emerg Med* 1994; 12(5):665-680

Runge JW. The Cost of Injury. *Em Med Clin NA* 1993; 11(1):241-254

Runge JW. Pneumonia in adults. *Crit Dec Emerg Med* 1990; 4:229-237

Runge JW. Pneumonia in children. *Crit Dec Emerg Med* 1990; 4:239-246

Runge JW. Orthopedic Problems in Pediatric Trauma. *Pediatric Trauma Management for EMS.* Charlotte NC, Hemby Pediatric Institute, M 53-58, 1989.

Runge JW. Schafermeyer RW. Respiratory emergencies. *Primary Care Clinics* 1986; 13(1):177-192

Editorials and Commentaries:

Runge JW Alcohol and Other Drug Problems among Hospitalized Trauma Patients: Controlling Complications, Mortality, and Trauma Recidivism. *J Trauma* 2005; 59: S43-S48.

Runge JW, Kanianthra JN. Risk analysis in road traffic injury research. *Ann Emerg Med* 2004; 44(2): 153-154.

Runge JW, Cole TB. Crosswalk Markings and Motor Vehicle Collisions Involving Older Pedestrians (ed.) *JAMA* 2002; 288:2172
Runge JW. Screening for alcohol use disorders - barriers and excuses. *Ann Emerg Med* 2000; 36(6): 629-630.

Runge JW. Antihistamines and driving performance – an under-recognized issue in traffic safety. [commentary] *Ann Emerg Med* 2000; 36: 389-390.

Runge JW. Disease control and crash injury – modifying host risk factors. [commentary] *Ann Emerg Med* 2000; 36:165-166.

Runge JW. Linking data for injury control research. *Ann Emerg Med* 2000; 35(6): 613-615.

Runge JW. Pediatric patients still ride in front of air bags. *Emergency Medicine Alert* 2000;6(9):68-69.

Runge JW. The new safer family of dummies [commentary]. *Ann Emerg Med* 1999;33:721-722.

Runge JW. Intubation difficulty in poisoned patients. *Emergency Medicine Alert* 1998;4(11):84-85.

Runge JW. Cell phones and the multitasking driver [commentary]. *Ann Emerg Med* 1998;31(2):278-280.

Runge JW. Use of troponin for diagnosis of ED patients with chest pain. *Emergency Medicine Alert* 1998;4(9):67-68.

Runge JW. Making physiologic sense of the diagnosis of pulmonary embolism: potential for a new diagnostic method. *Emergency Medicine Alert* 1997;4(7):49-50.

Runge JW. End-tidal CO_2 and CPR: Do we need technology or common sense? *Emergency Medicine Alert* 1997; 4(5):33-34.

Runge JW. Guest Editor. Emergency medicine: North Carolina's response. An issue of the *NCMJ* 1997;58(4).

Runge JW. Emerging success: finding a void and filling it. *NCMJ* 1997; 58(4): 235-236

Runge JW. A super alternative for wound closure: a new generation of cyanoacrylate. *Emergency Medicine Alert* 1997; 4(3):17-18

Runge JW. Do motorcycle helmets affect riders' vision and hearing? [commentary] *Ann Emerg Med* 1997, 29(2):283.

Runge JW. The economic cost of motor vehicle crashes, 1994 [commentary]. *Ann Emerg Med* 1996, 28(6):712.

Runge JW. NHTSA Crash-Injury Research and Engineering Network [commentary]. *Ann Emerg Med* 1996; 28(4):451-452

Runge JW. Bystander CPR: quality, not quantity. *Emergency Medicine Alert* 1996; 2(11):83-84

Runge JW. Man does not live by ACD alone. *Emergency Medicine Alert* 1995; 2(3):19-20

Runge JW. Triage by mechanism of injury: do we really need a trauma team? *Emergency Medicine Alert* 1995; 1(8):59

Runge JW. Crystalloid resuscitation challenged for penetrating injuries to the torso. *Emergency Medicine Alert* 1994; 1(7):49-50

Runge JW. Aminophylline does not improve CPR outcome. *Emergency Medicine Alert* 1994; 1(3):17-18

Runge JW. Transesophageal echocardiography for evaluation of thoracic aortic dissection. *Emergency Medicine Alert* 1994; 1(1):1-2

Runge JW. Informed consent: an unresolved issue [letter]. *Ann Emerg Med* 1990; 19(7):841

Published Abstracts:

Runge JW, Garrison HG, Shen G, Hall WL, Waller AE. Seat belt use and speeding among crash injury patients with alcohol use disorder. Acad Emerg Med 2001; 8(5):482

Runge JW, Cruz TH. Immunize children against injury - one patient at a time. Acad Emerg Med 2001; 8(5):587

Runge JW, Garrison HG, Hall WL, Waller A. Identification and referral of impaired drivers through ED protocols. *Acad Emerg Med* 2000; 5:436

Roberts EL, **Runge JW**. ED DIRECT: A method for ED-based alcohol abuse intervention. *Acad Emerg Med* 2000; 5:474-475

Runge JW, Garrison HG, Hall WL, Waller A. Prevalence of alcohol abuse or alcohol dependency in patients treated for motor vehicle crash injury. *Acad Emerg Med* 1999; 6(5):490-491

Runge JW, Andrews LL, Marx JA. Five year follow up study of injured intoxicated drivers. *Acad Emerg Med* 1998; 5(5): 542

Silverman R, Gallagher J, **Runge JW**, Osborne H, Feldman J, Kindshuh M, Gaeta T, Schwartz R. Pulmonary function of patients with severe asthma released from the emergency department. *Acad Emerg Med* 1997; 4(5): 483

Sloan EP, Luer M, Fischer J, Ramsay E, **Runge JW**, Philbrook B, Allen FH. Cardiac effects with high-dose, high-rate intravenous fosphenytoin seizure therapy. *Acad Emerg Med* 1997;4(5):380

Sweeney T, **Runge JW**, Gibbs MA, Carter JM, Schafermeyer RW, Norton JH. First responder defibrillation does not increase survival from sudden cardiac death in a two-tiered urban-suburban EMS system. *Acad Emerg Med* 1996; 3(5): 422

Silverman R, Osborn H, **Runge JW**, Gallagher EJ, Chiang W, Gaetha T, Feldman J, Scharf S, Mancherje N, Kwiatkkowski T, Freeman K. Magnesium sulfate as an adjunct to standard therapy in acute severe asthma. *Acad Emerg Med* 1996; 3(5): 467

Ramsay E, Philbrook B, Fischer JL, Sloan EM, Allen FH, **Runge JW**, Smith MF, Kugler AR. Safety, tolerance and pharmacokinetics of fosphenytoin compared to Dilantin following rapid IV administration. *Neurology* 1996; 46(suppl):A245

Runge JW, Sloan EP, Turnball TL, Fischer JH, Allen FH. Intravenous fosphenytoin loading for emergent seizure control. *Ann Emerg Med* 1995; 25(1):139

Allen FA, **Runge JW**, Legarda A, Maria BL, Matsuo R, Kugler AR, Knapp LE. Multicenter open-Label study on safety, tolerance, and pharmacokinetics of intravenous fosphenytoin in status epilepticus. *Epilepsia* 1994; 35(suppl):93

Garvey JL, Raymond RM, **Runge JW**, Schroeder D, Leonova E, Carter JM. Cocaine directly induces hypodynamic cardiotoxicity. *Acad Emerg Med* 1994; 1(3):320

Allen FH, **Runge JW**, Legarda S, Maria BL, Matsuo F, Kugler AR, Knapp LE. Multicenter, open-label study on safety, tolerance and pharmacokinetics of intravenous fosphenytoin in status epilepticus. *Epilepsia* 1994; 34(8):93

Brewer TO, Schafermeyer RW, **Runge JW**, Norton HJ. Transcutaneous PCO_2 compared with arterial PCO_2 for detecting CO_2 retention in the emergency department. *Acad Emerg Med* 1994; 1(2):A49

DiPasquale JT, Nichols JA, **Runge JW**. Can patients requiring a single physician evaluation be predicted at triage? *Acad Emerg Med* 1994; 1(2):A29

Legarda S, Maria BL, Matsuo F, Allen FH, **Runge JW**, Kugler AR, Marriott J. Safety, tolerance, and pharmacokinetics of fosphenytoin, a phenytoin prodrug, in status epilepticus. *Epilepsia* 1993; 34(6):60

Runge JW, De Stefano AA, Garvey JL, Quinn ME, Raymond RM. Adenosine mediates cardiac tachyphylaxis to catecholamines. *Ann Emerg Med* 1993; 22(5):893

Garvey JL, **Runge JW**, Schroeder JD, Leonova E, Carter JM, Raymond RM. Cardiodepressant effect of continuous cocaine infusion in anesthetized dogs. *FASEB J* 1993; 7(4):A684

Runge JW, Garvey JL, Schroeder JD, Leonova E, Rose FR, Raymond RM. Etomidate as a canine anesthetic in cardiovascular research. *FASEB J* 1993; 7(4):A708

Runge JW, Pulliam CL: Prosecution of injured alcohol-intoxicated drivers for DWI. *Ann Emerg Med* 1992; 21(5):590

Runge JW, Martinez JC, Caravati EM, Williamson SG, Hartsell SC: Cimetidine in the treatment of acute allergic reaction. *Ann Emerg Med* 1989; 18(4):475

Technical Reports:

Runge JW, Garrison H, Hall W, Waller A, Shen G. (2002). *Identification and Referral of Impaired Drivers through Emergency Department Protocols* (HS 809 412). Washington DC: National Highway Traffic Safety Administration.

Maio RF, **Runge JW**, Lewis DC. *The Spectrum of Alcohol Problems and the Scope of Emergency Medicine* (2002). *In* Alcohol Problems among Emergency Department Patients: Proceedings of a Research Conference on Identification and Intervention (Hungerford DW, Pollock DA, Eds). Atlanta GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Runge JW, Hargarten S, Velianoff G, Brewer PA, D'Onofrio G, Soderstrom CA, Gentilello LM, Flaherty L, Fiellin DA, Degutis LC, Pantalon MV. (2001). *Developing Best Practices of Emergency Care for the Alcohol-Impaired Patient: Recommendations from the National Conference* (DOT HS 809 281), Washington, DC: National Highway Traffic Safety Administration

16. Speeches:

a. Provide the Committee with two copies of any formal speeches you have delivered during the last 5 years which you have copies of and are on topics relevant to the position for which you have been nominated. Provide copies of any testimony to Congress, or to any other legislative or administrative body. (Attached)

b. Provide a list of all speeches and testimony you have delivered in the past 10 years, except for those the text of which you are providing to the Committee. Please provide a short description of the speech or testimony, its date of delivery, and the audience to whom you delivered it.

Speeches and Testimony Addresses (Past ten years):

Emergency Care in the U.S. Health System: History and Future. Institute of Medicine – National Academy of Sciences, Washington, DC, December 2006

Making New York safer: What individuals and organizations can do. Council on Foreign Relations, New York, NY, September 2006

Medical response to disasters: Are you prepared? (Keynote) American Association of Medical Society Executives, Montreal, Quebec, July 2006

DHS role in emergency medical response to disasters (plenary session). National Association of EMS Physicians, Tucson, AZ, January 2006

DHS role in emergency medical response to disasters (plenary session). American Ambulance Association, Las Vegas, NV, November 2004

Achieving a culture of safety worldwide (plenary session). 7th World Conference on Injury Prevention and Safety Promotion, Vienna, Austria, June 2004.

Increasing automotive safety through innovative engineering. Society of Automotive Engineers Industry and Government Meeting, Washington, DC, May 2004.

Promoting change for improved road safety. Motor and Equipment Manufacturers Association Legislative and Public Policy Summit, Washington, DC, May 2004.

Saving lives through data. Singapore General Hospital Grand Rounds, Singapore, Singapore, April 2004.

Global road safety. Asia-Pacific Economic Cooperation 23rd Meeting of the Transportation Working Group, Beijing, China, April 2004.

Highway safety priorities 2004 and beyond. Lifesavers 22, San Diego, CA, March 2004.

Highway safety priorities. Louisiana Highway Safety Commission Belts and Alcohol, Baton Rouge, LA, March 2004.

Motor vehicle safety in the United States. Rubber Manufacturers Association, Henderson, NV, March 2004.

Alcohol screening and brief intervention. National Medical Leaders Meeting, Washington, DC, February 2004.

Public health and the epidemic of motor vehicle crashes (plenary session). American Public Health Association, San Francisco, CA, November 2003.

Keeping children safe on our roadways (keynote). National SAFE KIDS Leadership Conference, Washington DC, October 2003.

Traffic safety in the United States. First General Assembly, International Association of Chiefs of Police Annual Conference, Philadelphia, PA, October 2003.

The impaired driving problem in the United States: progress and research needs. International Medical Advisory Group Conference, Niagara on the Lake, Ontario, Canada, October 2003.

Working party on road traffic safety (WP.1). United Nations Economic Commission for Europe, Geneva, Switzerland, September 2003.

The impaired driving problem in the United States. Mothers Against Drunk Driving Annual Conference, New Orleans, LA, September 2003.

A call to general quarters. Governors Highway Safety Association Annual Conference, New Orleans, LA, August 2003.

Saving lives through data. 29th International Traffic Records Forum. Denver, CO, July 2003.

The physician and public policy. American Association of Medical Society Executives, Boston MA, July 2003.

Traffic safety in the United States. Automotive Trade Association Executives . Brewster, MA, July 2003.

Painting the safety picture (panel). American Association of State and Highway Transportation Officials Conference, Lexington, KY, June 2003.

The role of IVI in highway safety (panel). 18th International Technical Conference on the Enhanced Safety of Vehicles, Nagoya, Japan, May 2003.

The emergency physician as policymaker. American College of Emergency Physicians Leadership and Legislative Issues Conference, Washington, DC, May 2003.

Safety in numbers: working together from research into practice, plenary session. Centers for Disease Control and Prevention Conference, Atlanta, GA (Washington DC, national web cast,), April 2003.

World forum for the harmonization of vehicle regulations. United Nations Economic Commission for Europe Meeting, Geneva, Switzerland, March 2003.

Partnerships to reduce impaired driving. National Hispanic Medical Association Meeting, Washington, DC, March 2003.

Federal transportation and safety partners. American Association of Motor Vehicle Administrators Legislative Summit, Washington, DC, March 2003.

Taking traffic safety to the next level. Lifesavers 21. Chicago, IL, March 2003.

Increasing bicycle safety. League of American Bicyclists Bike Summit. Washington, DC, March 2003.

Impaired driving programs of the National Highway Traffic Safety Administration. National Institute on Alcohol Abuse and Alcoholism National Advisory Council Meeting, Washington, DC, February 2003.

Route to reauthorization. Transportation Research Board Annual Meeting, Washington, DC, January 2003.

EMS injury prevention roundtable, State and Territorial Injury Prevention Directors Association, Washington DC, January 2003.

Meeting the safety challenge. Automotive News World Conference. Dearborn, MI, January 2003.

Public health and the epidemic of motor vehicle crashes. Boston and Harvard Universities School of
Public Health Forum, Boston, MA, December 2003.

Route to reauthorization. Federal Bar Association, Washington, DC, November 2002.

Final remarks, closing plenary session. Criminal Justice Summit, National Criminal Justice Association, Washington, DC, November 2002.

Transportation issues in bioterrorism: considerations for evacuation and quarantine. Federal interagency meeting on EMS Terrorism Preparation, Washington, DC, October 2002.

The highway safety challenge. American Association of State Highway and Transportation Officials Annual Meeting, Anchorage, AK, October 2002.

Put the brakes on the next drunk driver! American College of Emergency Physicians Annual Meeting, Seattle, WA, October 2002.

Highway safety priorities. American Association for the Advancement of Automotive Medicine Annual Meeting, Tempe, AZ, September 2002.

Global harmonization of vehicle regulations. Japan Automobile Standards Internationalization Center Annual Workshop, Tokyo, Japan, September 2002.

Motor vehicle safety in the United States. 3rd Motor Vehicle Safety Symposium, United Nations University, Tokyo, Japan, September 2002.

Highway safety priorities: Reaching 75% safety belt use in the United States. National Association of Governors Highway Safety Representatives Annual Conference, St. Louis, MO, September 2002.

16th International Council on Alcohol, Drugs and Traffic Safety, opening ceremony (panel). Montreal, Canada, August 2002.

The effect of public policies on mitigating the burden of injuries. 6th World Conference on Injury Prevention and Control. Montreal, Canada, May 2002.

Motor vehicle safety in the United States. National Conference of Black Mayors Annual Meeting, Jackson, MS, April 2002.

Trauma care and road safety – The William S. Stone Lecture. 29th National American Trauma Society Conference, Rosslyn, VA, April 2002.

"Biomedical Ethics – A Global Perspective," University of NC at Charlotte Conference on Global Health Disparities, Charlotte, NC, April 2001.

"Emergency Department Screening and Intervention for At-risk Drinkers," CDC Conference on Screening and Intervention, Arlington, VA, March 2001.

"Ethics in Emergency Research, Informed Consent, and the IRB," Emergency Medicine Basic Research Skills Workshop, Dallas TX, November 2000.

"Injury Prevention and Control in Emergency Medicine Practice," Grand Rounds, University of Indiana, Indianapolis, IN, September 2000.

"Ethical Issues in Emergency Research," Grand Rounds, Medical College of Wisconsin, Milwaukee, WI, September 2000.

"Federal Funding for Injury Control Research," Society for Academic Emergency Medicine, San Francisco, CA, May 2000.

"Crash Investigation: Engineering and Clinical Concepts," and "Linking the Medical Record and the Vehicle," Car Crash and Occupant Injury Course, Association for the Advancement of Automotive Medicine, Miami, FL, April 2000.

"Ethical Issues in Research Planning and Design," Emergency Medicine Foundation, Basic Research Skills Workshop, Dallas, TX, November 1999.

"Injury Biomechanics Workshop," American College of Emergency Physicians Scientific Assembly, Las Vegas, NV, October 1999.

"Triage Decisions in the Practice of Injury Control," NC Chapter, American Trauma Society, Hickory, NC, April 1999.

"Evidence-Based Triage of Injury," ENA/ENCARE National Leadership Symposium, Los Angeles, CA, February 1999.

"Screening and Referral of Injured Impaired Drivers," ENA/ENCARE National Leadership Symposium, Los Angeles, CA, February 1999.

"Injured Impaired Drivers and the Medical Community," National Academy of Sciences, Transportation Research Board, Washington, DC, January 1999.

"Ethical and Regulatory Issues in Human Subject Research," Emergency Medicine Foundation, Basic Research Skills Workshop, Dallas, TX, November 1998.

"From Hypothesis to Pharmacy: The Drug Research & Development Process," Community Conference on Clinical Research, Bioethics Resource Group, Charlotte, NC, September 1998.

"Community-Based Injury Control: The Future of Injury Reduction" Alabama Safe Communities Workshop, Birmingham, AL, July 1998.

"Research Ethics and the IRB"
"How to be a Successful Clinical Trials Investigator"
Society for Academic Emergency Medicine, Chicago, IL, May 1998.

"DUI and the Medical Community - To Report or Not to Report Suspected Offenders" Lifesavers '98, Cleveland, OH, March 1998.

"Diagnosis and Treatment of Seizures in an Acute Care Setting" Emergency Medicine Grand Rounds, Orlando Regional Medical Center, Orlando, FL, February 1998.

"Partners in Progress: Reaching the National Goal through Innovative Alcohol Research" National Academy of Sciences, Transportation Research Board, Washington, DC, January 1998.

"Ethical and Regulatory Issues in Human Subject Research", Emergency Medicine Foundation, Basic Research Skills Workshop, Dallas, TX, November 1997.

"Emergency Research and Exception to Informed Consent" FDA/NIH Workshop: Contemporary issues in human subjects research, Charlotte, NC, September 1997.

"Fundamentals of Research: Research Ethics and Human Subjects" Society for Academic Emergency Medicine, Washington, DC, May 1997.

"Preserving Your Research Career" Research Directors Workshop, Society for Academic Emergency Medicine, Washington, DC, May 1997.

"Multi-center Clinical Research Workshop" Society for Academic Emergency Medicine, Washington, DC, May 1997.

Congressional and State Testimony:

The DHS Response to Isolation and Quarantine of XDR Tuberculosis. Jeffrey W. Runge, MD, Assistant Secretary for Health Affairs (Acting) and DHS Chief Medical Officer, before the Committee on Homeland Security, U.S. House of Representatives, June 6, 2007.

The Role of the Department of Homeland Security Under Project BioShield. Jeffrey W. Runge, MD, DHS Chief Medical Officer, before the Subcommittee on Emerging Threats, Cybersecurity and Science and Technology, Committee on Homeland Security, U.S. House of Representatives, April 18, 2007.

The DHS Office of Health Affairs FY 2008 Budget Request. Jeffrey W. Runge, MD, DHS Chief Medical Officer, before the Subcommittee on Homeland Security, Committee on Appropriations, U.S. House of Representatives, March 29, 2007.

The Avian Influenza Threat and the Role of the Department of Homeland Security in Coordinating the Federal Response to an Influenza Pandemic. Jeffrey W. Runge, MD, DHS Acting Under Secretary for Science and Technology and Chief Medical Officer, before the Committee on Government Reform, U.S. House of Representatives, May 11, 2006.

The role of the DHS Chief Medical Officer. Jeffrey W. Runge, M.D., Chief Medical Officer, Department of Homeland Security, before the Subcommittee on Management, Integration and Oversight, Committee on Homeland Security, United States House of Representatives, October, 2005.

The TREAD Act and Motor Vehicle Safety. Jeffrey W. Runge, M.D. Administrator, National Highway Traffic Safety Administration, before the Senate Subcommittee on Competition, Foreign Commerce and Infrastructure, United States Senate, Washington, DC, on June 3, 2004.

NHTSA's FY 2005 Budget Request. Jeffrey W. Runge, M.D. Administrator, National Highway Traffic Safety Administration, before the House Subcommittee on Transportation, Treasury and Independent Agencies of the Committee on Appropriations, United States House of Representatives, Washington, DC, on March 25, 2004.

Motor Vehicle Safety. Jeffrey W. Runge, M.D. Administrator, National Highway Traffic Safety Administration, before the House Subcommittee on Commerce, Trade and Consumer Protection, United States House of Representatives, Washington, DC, on March 18, 2004.

The Merits of House Bill 1200 (Primary Safety Belt Law). Jeffrey W. Runge, M.D. Administrator, National Highway Traffic Safety Administration, before the Missouri House Transportation and Motor Vehicle Safety Committee, Jefferson City, MO, on February 11, 2004.

The Merits of Senate Bill 40 (Primary Safety Belt Law). Jeffrey W. Runge, M.D. Administrator, National Highway Traffic Safety Administration, before the Senate

Highways and Transportation Committee, Ohio Senate, Columbus, OH, on February 3, 2004.

The Merits of Senate Bill 125 (Primary Safety Belt Law). Jeffrey W. Runge, M.D. Administrator, National Highway Traffic Safety Administration, before the Senate Transportation and Homeland Security Committee, Indiana General Assembly, Indianapolis, IN, on January 20, 2004.

NHTSA's Highway Safety Programs: The Bush Administration's Proposal for Reauthorization (SAFETEA). Jeffrey W. Runge, M.D. Administrator, National Highway Traffic Safety Administration, before the Subcommittee on Competition, Foreign Commerce, and Infrastructure Committee on Commerce, Science, and Transportation United States Senate, Washington, DC, on May 22, 2003.

NHTSA's 2004 Budget Request. Jeffrey W. Runge, MD, Administrator, National Highway Traffic Safety Administration, before the Subcommittee on Transportation, Treasury and Independent Agencies of the Committee on Appropriations United States House of Representatives, Washington, DC, on April 3, 2003.

The Merits of a Primary Safety Belt Law. Jeffrey W. Runge, MD, Administrator, National Highway Traffic Safety Administration before the Joint Committee on Public Safety of the Massachusetts Legislature, Boston, MA, on April 1, 2003.

SUV Safety. Jeffrey W. Runge, MD, Administrator, National Highway Traffic Safety Administration before the Committee on Commerce, Science, and Transportation United States Senate, Washington DC, on February 26, 2003.

Highway Safety in the United States. Jeffrey W. Runge, MD, Administrator, National Highway Traffic Safety Administration, before the Subcommittee on Highways and Transit Committee on Transportation and Infrastructure, United States House of Representatives, Washington, DC, on June 27, 2002.

NHTSA's FY 2003 Budget and Programs. Jeffrey W. Runge, MD, Administrator, National Highway Traffic Safety Administration, before the Transportation Subcommittee of the Committee on Appropriations, United States House of Representatives, Washington, DC, on March 7, 2002.

Implementation of the TREAD Act. Jeffrey W. Runge, M.D. Administrator, National Highway Traffic Safety Administration, before the Subcommittee on Commerce, Trade, and Consumer Protection, Committee on Energy and Commerce, United States House of Representatives, Washington, DC, on February 28, 2002.

NHTSA's FY 2003 Budget and Programs. Jeffrey W. Runge, M.D. Administrator, National Highway Traffic Safety Administration, before the Transportation

Subcommittee of the Committee on Appropriations, United States Senate, Washington, DC, on February 27, 2002.

Joint DOT Modal Statement on TEA-21 Preauthorization. Statement of Mary E. Peters - Administrator Federal Highway Administration, Jennifer L. Dorn - Administrator Federal Transit Administration, Joseph M. Clapp - Administrator Federal Motor Carrier Safety Administration, Jeffrey W. Runge, M.D. - Administrator National Highway Traffic Safety Administration - United States Department of Transportation, before the Subcommittee on Highways and Transit Committee on Transportation and Infrastructure, United States House of Representatives, Washington, DC, on February 7, 2002.

Statement on Corporate Average Fuel Economy. Jeffrey W. Runge, Administrator, National Highway Traffic Safety Administration, before the Committee on Commerce, Science, and Transportation, United States Senate, Washington, DC, on December 6, 2001.

17. Selection:

a. Do you know why you were chosen for this nomination by the President?

When Secretary Chertoff and Deputy Secretary Jackson asked me to join the Department in the summer of 2005, they made it clear that a top priority was to find managers with Federal government management experience as well as subject matter expertise. I had just completed four years as head of the National Highway Traffic Safety Administration (NHTSA), where I had the opportunity to reorganize the agency to better execute its mission and provide a more focused strategic plan. I was fortunate to work closely with Congress and private sector industry to implement programs that brought about the first absolute reduction in motor vehicle fatalities in nearly a decade. Those same skills were needed in the young Department of Homeland Security. I accepted the appointment by Secretary Michael Chertoff to become the Department of Homeland Security's first Chief Medical Officer in September of 2005. Since that time, I have worked to establish the Office of the Chief Medical Officer, which was authorized by Congress in September 2006 (P.L. 109-295). That authorization specified that the Chief Medical Officer be appointed by the President and confirmed by the Senate. By the end of the first year, our needs assessment for the Department made it clear that it needed a comprehensive approach to biodefense, WMD consequence planning and incident management coordination for events with medical consequences, and DHS workforce health protection. The Secretary established the DHS Office of Health Affairs on March 31, 2007 to accomplish that mission, and with the concurrence of Congress, established that the title of Assistant Secretary be conferred on the head of the office. I am honored that the President has chosen to have me

continue my service to the American people as the first DHS Assistant Secretary for Health Affairs and Chief Medical Officer.

b. What do you believe in your background or employment experience affirmatively qualifies you for this particular appointment?

I have over 25 years of experience in medical care and public health and safety policy. My research and academic pursuits have been centered in the area of applied public health, primarily injury prevention and control, culminating with my service to the Administration as the head of NHTSA. I have extensive experience in the field of Emergency Medical Services as a teacher, manager, and medical control officer, and as the head of NHTSA, the Federal agency responsible for EMS. I was responsible for several aspects of local medical disaster planning in my home town of Charlotte, NC. I have extensive experience working with state and local government, particularly law enforcement and the first responder community, while in North Carolina and in my work at NHTSA.

In my capacity as Chief Medical Officer, I serve as the principal advisor to the Secretary for public health and medical issues across the Department. I am responsible for coordination with other Federal departments and agencies and the Homeland Security Council on issues of biodefense and medical preparedness, including pandemic planning.

I served as the Acting Under Secretary for DHS S&T during most of 2006, where I led the transformation of S&T into a customer-driven organization to serve the Department's needs for research, development, testing, evaluation and certification of technologies for defense of the homeland, while putting into place more rigorous fiscal control over the taxpayers' dollars.

I believe the best qualification I can cite is my experience managing a Federal agency with approximately 900 employees and contractors and a budget of over $600 million. Our programs in highway safety and innovations in vehicle safety have resulted in literally thousands of lives being saved on our nation's highways, which are still paying benefits to the American people. Our accomplishments of 2001-2005 include:

- **An increase in safety belt use from 71% in 2000 to 82%, a difference of over 2000 lives a year, though our nationwide "Click It or Ticket" program;**
- **Led the Nation's first decrease in absolute numbers of highway deaths since the early 1990's;**
- **Oversaw the largest decrease in numbers of alcohol-related fatalities since 1992 through an innovative partnership with States and law enforcement agencies;**
- **Drove the redesign of SUVs to decrease rollover crashes through our "5-star" consumer rating program;**

- **Raised fuel economy standards for light trucks to save energy for the nation – a larger increase than all increases cumulatively since 1986;**
- **Promoted improvements in automated crash avoidance systems in vehicles, such as electronic stability control that lowers deaths in light trucks by 60% and will soon become standard equipment.**
- **Improved NHTSA's data systems, raising numbers of cases on the National Automotive Sampling System, improving safety belt surveys to include back seat and child safety seat usage, and leading the creation of a defects detection system mandated by Congress.**

B. EMPLOYMENT RELATIONSHIPS

1. Will you sever all connections with your present employers, business firms, business associations or business organizations if you are confirmed by the Senate?

   I am currently employed by the Department of Homeland Security.

2. Do you have any plans, commitments or agreements to pursue outside employment, with or without compensation, during your service with the government? If so, explain.

   Per my ethics agreement, I will continue to serve as an uncompensated trustee for the Emily C. Runge Revocable Trust and Virginia Deck Runge Irrevocable (Life Insurance) Trust. Pursuant to18 U.S.C. §208, I will not participate personally and substantially in any particular matter that will have a direct and predictable effect on the financial interests of these organizations, unless I first obtain a written waiver under 18 U.S.C. § 208(b)(1). Upon confirmation, I will resign from my position of managing partner for Tuckaway Partners, Limited Liability Company (LLC), a real estate LLC owned only by my wife and me. I may elect to dissolve the LLC, since it currently has no holdings other than cash.

   Pursuant to 18 U.S.C. §208, I will not participate personally and substantially in any particular matter that will have a direct and predictable effect on the financial interests of these organizations, unless I first obtain a written waiver under 18 U.S.C. § 208(b)(1).

3. Do you have any plans, commitments or agreements after completing government service to resume employment, affiliation or practice with your previous employer, business firm, association or organization, or to start employment with any other entity? **No**

4. Has anybody made a commitment to employ your services in any capacity after you leave government service? **No**

5. If confirmed, do you expect to serve out your full term or until the next Presidential election, whichever is applicable? **Yes**

6. Have you ever been asked by an employer to leave a job or otherwise left a job on a non-voluntary basis? **No**

C. POTENTIAL CONFLICTS OF INTEREST

1. Describe any business relationship, dealing or financial transaction which you have had during the last 10 years, whether for yourself, on behalf of a client, or acting as an agent, that could in any way constitute or result in a possible conflict of interest in the position to which you have been nominated. **None**

2. Describe any activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat or modification of any legislation or affecting the administration or execution of law or public policy, other than while in a federal government capacity.

   Before joining the Federal government, I was active in North Carolina in advocating for legislation in the areas of highway safety and public health. I also served as a member of the N.C. Medical Political Action Committee and advocated for and against numerous pieces of State legislation affecting the practice of medicine in North Carolina.

3. Do you agree to have written opinions provided to the Committee by the designated agency ethics officer of the agency to which you are nominated and by the Office of Government Ethics concerning potential conflicts of interest or any legal impediments to your serving in this position? **Yes**

D. LEGAL MATTERS

1. Have you ever been disciplined or cited for a breach of ethics for unprofessional conduct by, or been the subject of a compliant to any court, administrative agency, professional association, disciplinary committee, or other professional group? **No**

2. Have you ever been investigated, arrested, charged or held by any Federal, State, or other law enforcement authority for violation of any Federal, State, county, or municipal law, regulation or ordinance, other than a minor traffic offense? **No**

3. Have you or any business of which you are or were an officer ever been involved as a party in interest in an administrative agency proceeding or civil litigation?

   A civil litigation case entitled "Daniel Phillips vs. Carolina HealthCare System and Jeffrey W. Runge, MD" was a third party lawsuit filed in Mecklenburg County, North Carolina court in 2000 by an individual with no personal or professional relationship to the defendants. The case had no merit and was thus

dismissed by the judge in response to a petition from the defense within a few weeks of filing.

As the Administrator of the NHTSA, our "business" was routinely sued by various parties, such as Public Citizen, opposing our rules or judgments. We also had a typical number of administrative complaints related to personnel issues.

As Under Secretary for Science & Technology, we were the subject of a single EEO complaint alleging gender discrimination subsequent to a suspension of an employee for misconduct. That complaint is pending as of August 24, 2007. The DHS General Counsel judges it to be without merit.

4. Have you ever been convicted (including pleas of guilty or *nolo contendere*) of any criminal violation other than a minor traffic offense? **No**

5. Please advise the Committee of any additional information, favorable or unfavorable, which you feel should be considered in connection with your nomination.

E. FINANCIAL DATA

All information requested under this heading must be provided for yourself, your spouse, and your dependents. (This information will not be published in the record of the hearing on your nomination, but it will be retained in the Committee's files and will be available for public inspection).

AFFIDAVIT

Jeffrey William Runge being duly sworn, hereby states that he/she has read and signed the foregoing Statement on Biographical and Financial Information and that the information provided therein is, to the best of his/her knowledge, current, accurate, and complete.

Subscribed and sworn before me this 24th day of August, 2007

Notary Public 6-30-08

U.S. Senate Committee on Homeland Security and Governmental Affairs
Pre-hearing Questionnaire
For the Nomination of Jeffrey W. Runge to be
Assistant Secretary for Health Affairs and Chief Medical Officer (CMO), at
the Department of Homeland Security (DHS)

I. Nomination Process and Background

1. Why do you believe the President nominated you to serve as Assistant Secretary for Health Affairs and CMO?

When he asked me to join the Department of Homeland Security in the summer of 2005, then-Deputy Secretary Michael Jackson made it clear to me that Secretary Michael Chertoff's top organizational priority was to find managers with Federal government management experience and specific subject matter expertise to build out the Department's senior staff. I had just completed four years as Administrator of the National Highway Traffic Safety Administration (NHTSA), where I had the opportunity to reorganize the agency to better execute its mission and provide a more focused strategic plan. I was fortunate to work closely with Congress and private sector stakeholders to implement programs that brought about the first absolute reduction in motor vehicle fatalities in nearly a decade. Those same skills were needed in the young Department of Homeland Security.

I accepted the appointment by Secretary Michael Chertoff to become the Department of Homeland Security's first Chief Medical Officer (CMO) in September of 2005. Over the following year, I worked to establish the Office of the Chief Medical Officer, which was authorized by Congress a year later (P.L. 109-295). That authorization specified that the CMO be appointed by the President and confirmed by the Senate. The law also required a reorganization of FEMA and the Preparedness Directorate, which forced a re-examination of the role of the Office of the Chief Medical Officer and its location in the Department's organization.

As part of that reorganization, the Secretary established the DHS Office of Health Affairs as of March 31, 2007, with the concurrence of Congress, and established that the title of Assistant Secretary be conferred on the Chief Medical Officer. I am honored that the President has chosen to have me continue my service to the American people as the first DHS Assistant Secretary for Health Affairs and Chief Medical Officer, to continue to establish the Office and its offices and divisions, and to finish what I started.

2. Were any conditions, express or implied, attached to your nomination? If so, please explain.

No conditions are attached to my nomination.

3. The "Post-Katrina Emergency Management Reform Act of 2006" (P.L. 109-295) (Post-Katrina Act) created the office of CMO and required the individual appointed to be CMO to possess a demonstrated ability in, and knowledge of, medicine and public health. What specific background and experience affirmatively qualifies you to be CMO?

I have over 25 years of experience practicing medicine, teaching and doing research in public health and safety policy. My research and academic pursuits have been centered in the area of applied public health, primarily injury prevention and control, culminating with my service to the Administration as the Administrator of the NHTSA. I have extensive experience in the field of Emergency Medical Services (EMS) as a teacher, manager, and medical control officer, and as the head of NHTSA, the Federal agency responsible for EMS. I have been responsible for local medical disaster planning in my home town of Charlotte, NC. I have extensive experience working with State and local government, particularly law enforcement and the first responder community while in North Carolina and through my work at NHTSA. Prior to coming to Washington, I spent a large amount of time interacting with members on both sides of the aisle in the N.C. General Assembly on public policy issues related to injury control and provision of health care to the underserved. I served on four Gubernatorial Task Forces of two governors (one on Injury Control, two on impaired driving, and one on the implementation of Healthy People 2010).

In my capacity as CMO, I serve as the principal advisor to the Secretary and the FEMA Administrator for health security and medical issues involving the Department. I am responsible for coordination with other Federal departments and agencies and the Homeland Security Council on issues of biodefense and medical preparedness, including pandemic planning.

I served as the Acting Under Secretary for the DHS Science and Technology Directorate (S&T) during much of 2006, where I led the transformation of S&T into a customer-driven organization to serve the Department's needs for research, development, testing, evaluation and certification of technologies for defense of the homeland, while putting into place more rigorous fiscal and other management controls to ensure best use of the taxpayers' dollars. I was also responsible for resourcing and organizing a first class research compliance program.

I believe my demonstrated success in managing a moderate-sized Federal agency is the best qualification I can cite for this appointment. Under my leadership, NHTSA's highway safety programs and innovations in vehicle safety resulted in literally thousands of lives being saved on our nation's highways. Moreover, those accomplishments are still paying benefits to the American people. Notable accomplishments from 2001-2005 include:

- Developed the nationwide "Click It or Ticket" program which led to an increase in safety belt use from 71% in 2000 to 82% in 2005, resulting in the saving of over 2000 lives a year;

- Led the Nation's first decrease in absolute numbers of highway deaths since the early 1990s;
- Oversaw the largest decrease in numbers of alcohol-related fatalities since 1992 through an innovative partnership with States and law enforcement agencies;
- Drove the redesign of SUVs to decrease rollover crashes through our "5-star" consumer rating program;
- Raised fuel economy standards for light trucks to save energy for the nation – a larger increase than all increases cumulatively since 1986;
- Promoted improvements in automated crash avoidance systems in vehicles, such as electronic stability control that lowers deaths in light trucks by 60% and will soon become standard equipment on all light trucks, including SUVs; and
- Improved NHTSA's data systems, raising numbers of cases included in the National Automotive Sampling System, improving safety belt surveys to include back seat and child safety seat usage, and led the creation of a defects detection system mandated by Congress in the TREAD Act.

4. Have you made any commitments with respect to the policies and principles you will attempt to implement as Assistant Secretary for Health Affairs and CMO? If so, what are they, and to whom were the commitments made?

   I have made numerous commitments to the Secretary and the Homeland Security Council to help craft and implement policies and principles in the areas of biodefense, integrated planning and incident management, DHS workforce health protection and as the advisor to the Secretary and the principals in DHS' operating components. I have briefed the Chairman, Ranking Member and Committee staff on the strategic plan, policies, goals, objectives and metrics necessary to implement those commitments. I would be pleased to re-visit this information at any time.

   Since drafting the FY 2007 version of OHA's strategic plan, additional policy-making and legislative activity has altered OHA's mission. Such activities include the ongoing planning for response to a pandemic and various types of weapons of mass destruction (WMD); Homeland Security Presidential Directives 18 ("Medical Countermeasures Against WMD" and -21 ("Public Health and Medical Preparedness"); the Pandemic and All Hazards Preparedness Act of 2006; and additional fiscal resources provided by Congress. We are currently revising our strategic plan to incorporate such changes in the environment. I anticipate issuing a revised strategic plan by the end of the 2nd quarter of FY 2008.

5. If confirmed, are there any issues from which you may have to recuse or disqualify yourself because of a conflict of interest or the appearance of a conflict of interest? If so, please explain what procedures and/or criteria you will use to carry out such a recusal or disqualification.

   I have reviewed my interests and affiliations with the Department's ethics official, Mr. Robert Coyle, in the past in relation to my existing duties as the Chief Medical Officer and most recently in connection with the duties of the office of Assistant

Secretary for Health Affairs. Those discussions have identified possibilities for conflicts to arise. Those potentials have been discussed both within the Department and with the U.S. Office of Government Ethics. I believe that the ethics agreement I have executed and which has been provided to the Committee will appropriately address those conflicts. I am committed to observing the highest ethical standards. I will be alert for the possibility of a conflict and will work closely with the agency's ethics counsel to ensure that any conflict is identified early and dealt with promptly and appropriately.

6. Have you ever been asked by an employer to leave a job or otherwise left a job on a non-voluntary basis? If so, please explain.

No.

II. Background of the Nominee

7. What do you consider to be your significant accomplishments and successes in the time you have served as Acting Assistant Secretary for Health Affairs and CMO?

The most significant accomplishment has been the successful implementation of Secretary Chertoff's vision to establish the Office of the Chief Medical Officer (OCMO). Since receiving congressional authorization for the Office of the Chief Medical Officer, we have created a strategic plan and briefed it to over 35 members of Congress. We have brought together the operational biodefense programs previously scattered through DHS, have requested and received interim funding through a re-programming of funds in 3Q FY07, and have put the core of people in place to execute the important work of the OHA. We have created a business infrastructure of management professionals and continue to manage programs and efforts begun as the OCMO while tackling the new challenges of the OHA.

Selected programmatic accomplishments follow:

- Led DHS efforts related to pandemic preparedness
  - Developed a strategic plan for DHS for pandemic influenza
  - Developed a plan for border management during a pandemic
  - Guided modeling and other significant research to inform the planning
  - Participated in a broad cooperative interagency effort for policy coordination and exercises
  - Participated as a principal in the North American Plan under the Security and Prosperity Partnership
  - Established, with our Office of Operations Coordination, a system for national incident management of pandemic, pre-designating a Principal Federal Official (PFO) and Regional PFOs
  - Created employee training tools for self-protection from infectious diseases including influenza.

- Provided real-time medical support to the Secretary and the operating component principals to manage the Department's responsibilities during actual incidents, including: BioWatch actionable results, the tainted pet food incident, a case of suspected foot-and-mouth disease, FEMA travel trailer formaldehyde issue, and tuberculosis-border crossing cases.

- Worked to establish a seamless relationship with partner Federal agencies, including:
    - The Department of Health and Human Services, and particularly the HHS Assistant Secretary for Preparedness and Response, the FDA, and various components of the CDC
    - Department of Defense – Homeland Defense, Health Affairs, and NORTHCOM
    - Various units of the US Department of Agriculture
    - Department of State – Democracy and Global Affairs

- Organized and led the DHS workgroup on the health and safety of imported goods, and represented DHS on an interagency Principals working group.

- Crafted a Memorandum of Agreement with HHS to set conditions for assigning officers of the U.S. Public Health Service to DHS, and to facilitate the transfer of the Immigration Health Service to DHS.

- Realigned the relationship between HHS and DHS with respect to projects and activities under Project BioShield and use of the Special Reserve Fund.

- Assumed operational control of the BioWatch program and the deployment of next generation biological materials detection.

- Assumed control of the National Biosurveillance Integration System (NBIS) project, which necessitated a significant change in direction, shifting focus more toward the interagency partnership than strictly an information technology enterprise. We worked with Congress to authorize the National Biosurveillance Integration Center (NBIC) to house the interagency group. To date, we have signed MOUs from six Federal departments for collaboration and use of data.

- Established a 24-hour watch desk capability for OHA, located in the National Operations Center, with direct feeds from the NBIC and BioWatch.

- Established lines of authority and responsibility with the Office of the Undersecretary for Management with respect to the Department's occupational safety and health and workforce protection.

- Participated in key Katrina after action recommendations, including solidifying various medical response assets for ERSF-8.

- Participated in the transitioning of NDMS to HHS.

8. In what areas, if any, have you failed to accomplish your goals?

The OHA is responsible for ensuring that there are national end-to-end plans in place for the biological planning scenarios – attacks by anthrax, pneumonic plague, foot and mouth disease, food-borne pathogens and pandemic influenza. Our commitment to the Secretary was to have all of these plans and playbooks completed by September of 2008. This program is off schedule, and although the goal will be met, it is unlikely to be accomplished during my tenure as I had planned.

Our job in this planning process is to provide the strategic guidance, assemble the interagency subject matter expertise, and supply contract planners to the DHS Incident Management Planning Team, who is then responsible for writing the plans. The resources for this effort were to be provided by a reprogramming requested in April 2007 and the FY 08 budget for OHA. (The President's budget requested $117 million for the OHA, including the transfer of BioWatch and NBIC to OHA). Congress did not approve the reprogramming request until June 2007. Since that time we have been able to fill and get on board one Federal employee position to supervise the process. Under the current Continuing Resolution, OHA is operating at its FY 07 budget of $4.9 million, so there is no money to support the program of work. Moreover, the Senate version of the FY 08 appropriations bill leaves OHA with a $3 million shortfall relative to both the President's budget and the House-passed mark. These are program funds needed to perform the important functions detailed in the OHA strategic plan, including the aforementioned plans for biological terrorist attacks.

9. How do you communicate to Office of Health Affairs (OHA) staff on efforts to address relevant issues?

In my current capacity as Acting Assistant Secretary for Health Affairs and CMO, I am in constant communication with my Deputy, Chief of Staff and three Associate Chief Medical Officers (ACMOs). We hold a weekly meeting with all of the ACMOs, Office Directors and Division heads.

I operate with an open-door policy to all OHA employees and maintain a high visibility daily rapport that is consistent with open-door management practices. I encourage OHA senior staff to follow the same principles to convey cohesiveness in the work place and to reinforce a general policy of "surge participation" when the demand for productivity exceeds the normal capacity in any OHA office or division. Everyone in our small office is expected to perform any duty in their skills set, but they seldom need to be asked. These are skilled physicians, veterinarians, nurses, scientists and administrative employees. No element of the OHA is more than one or two people deep, so they support and cover each other for meetings, conferences, and

other assignments. This mode of operation has resulted in a broad range of experience among the OHA work force, and the ability to "surge" in the event of an emergency.

For incident management and communications, OHA maintains a seat in the DHS National Operations Center (NOC) which is staffed by Officers in the US PHS trained to screen and analyze data coming in from the NOC, the NBIC, BioWatch, and the HHS Secretary's Operations Center (SOC). They serve as a 24/7 urgent notification system with the capability handle information to and from OHA senior managers. Our physicians and veterinarians provide a "doctor on call" 24/7 for the NOC, the Secretary, and the DHS component heads to consult for any incident.

10. In your responses to the Committee's biographical questionnaire, you mentioned innovative work with State and local law enforcement officers that had resulted in increased drunk driving arrests and consequently lower rates of drunk driving. What lessons did you learn from that experience (or others) that you have brought to your new role at DHS? Does your office have a specific coordinator to work with State and local officials or to relay State and local officials' concerns up the chain of command at DHS?

My approach to standing up the OCMO followed the same approach that I used to drive my agenda at the National Highway Traffic Safety Administration. State and local law enforcement officers and the private sector constituted the backbone of my efforts to improve seatbelt usage and reduce impaired driving deaths across the country. I worked closely to build personal relationships with the International Association of Chiefs of Police, State and Provincial Police, Major Cities Chiefs, National Sheriffs Association, along with governors, mayors, State legislators, public health and medical professionals involved with health and safety issues in their communities. I also had ongoing dialogue with safety advocacy groups, the auto industry, and the alcohol industry. Any success I achieved at NHTSA was the result of building relationships across all levels of government and the private sector. Preparedness, as it is with traffic safety, is a local phenomenon. If it doesn't happen at the local level, it doesn't happen.

As a new Office with responsibility for health security and preparedness, it was important from the beginning to establish who our stakeholders were, to reach out to those potential partners both internally and externally, and to acquaint them with the OCMO and how we fit it to the DHS mission. Early on, much of my time was spent reaching out to build a DHS constituent base among organizations that had not previously been invited in to the DHS stakeholder group. This included the American Medical Association, various medical specialty and allied health organizations, the American Public Health Association, Association of State and Territorial Health Officials, National Association of City and County Health Officials, emergency medical services organizations, national veterinary professional organizations, and many universities and business and industry groups. This outreach included numerous meetings, briefings and speaking engagements to involve them in our planning and programmatic activities.

In our strategic plan and on our organizational chart, we have the Division of Emergency Management and Medical Response within the Office of Medical Readiness. We have budgeted sufficient funds in FY08 to staff the division and begin the long process of outreach with the regional, State and local emergency management and health officials. These relationships must be established so that we have complete vertical integration with our bioterrorism planning and seamless interagency relationships during the management of a catastrophic incident. Our office needs to collaborate with regional FEMA officials, HHS Regional Emergency Preparedness officials, DHS Infrastructure Protective Service Advisors and FEMA regional grants coordinators, so that State, local, and tribal officials and the private sector receive a unified message from the Federal government on medical readiness and health system preparedness.

This activity will require one person in each of the ten Federal regions, co-located with our collaborators. This is not budgeted for FY08, but is being considered as part of the normal executive branch budget process.

Even though we do not yet have a regional footprint, our OHA staff is in frequent contact with State and local officials around the country. The issues range from emergency medical services to food, agriculture, and veterinary security. The regular interaction with State and local officials and any concerns or issues they might have is quickly brought to the attention of OHA senior management and if necessary brought to the attention of any affected DHS component or DHS' senior management.

III. Role and Responsibilities of the Assistant Secretary for Health Affairs and CMO

11. Why do you wish to serve as Assistant Secretary for Health Affairs and CMO?

Our needs assessment for the Department made it clear that DHS requires a comprehensive approach to biodefense, WMD consequence planning and incident management coordination for events with health security consequences, and a program to address DHS workforce health protection. Secretary Chertoff established the Office of Health Affairs in March of 2007 to accomplish that mission. I am eager to continue this important work, as I believe that the mission is too important not to complete the job I started.

12. What is your view of the role of the Assistant Secretary for Health Affairs and CMO?

The role of the Assistant Secretary for Health Affairs is to serve as the principal medical advisor to the Secretary, lead DHS' biodefense efforts, lead the DHS efforts in WMD consequence planning and incident management coordination for events with health security consequences, and to ensure that the Department has unified and medically sound policies for occupational health security, including appropriate workforce protection.

13. You have been nominated to be the Assistant Secretary for Health Affairs and the Chief Medical Officer at the DHS. The position of the Chief Medical Officer was created by the Post-Katrina Act and the Act describes the duties of such position.

    a. What is the significance of the additional position of Assistant Secretary of Health Affairs? Why is it necessary?

    The addition of "Assistant Secretary for Health Affairs" to the CMO's title does not indicate an additional position; instead, it is one position that fulfills the statutory duties outlined in Sec. 516 of the Post Katrina Emergency Management Reform Act of 2006 (Post Katrina Act).

    The duties of the Assistant Secretary and the responsibilities of the Office of Health Affairs (OHA) go beyond what was initially anticipated for a Chief Medical Officer (CMO) established under the "Second Stage Review." When the position was originally contemplated, it was largely an incident management and advisory role with a small staff within the Preparedness Directorate. As one of many examples of the expanded mission, OHA is responsible for consolidating and managing the Department's biodefense programs, including BioWatch, the National Biosurveillance Integration Center, the Office of Food, Agriculture and Veterinary Defense, and the Department's equities in Project BioShield. This includes a majority of the Department's deliverables under HSPD-9, *Defense of U.S. Agriculture and Food*, and HSPD-10, *Biodefense for the 21st Century*. OHA has been given the responsibility for the national planning for the biological planning scenarios – attacks by anthrax, pneumonic plague, foot and mouth disease, food-borne pathogens and pandemic influenza, along with the requirements resulting from those plans to drive grant funding for training, equipment and exercises. OHA has committed to setting up mechanisms and institutions for integration with regional, State, local and tribal entities who will be carrying out the planning and response to all-hazards incidents, including bioterrorism and natural disasters with health consequences, in coordination and collaboration with the Department of Health & Human Services and the other leads for the Emergency Support Functions under the National Response Framework. OHA is also responsible for all of the policy, standards and metrics for DHS workforce protection and occupational health, and for medical oversight of all health and safety activities in the Department. These additional responsibilities filled gaps in the young organization that had not been previously performed under any one authority.

A copy of the organizational chart for the Office of Health Affairs is attached as Attachment A and for the Department as Attachment B.

The Department provided the notice to Congress on January 18, 2007 of its intent to use the title "Assistant Secretary of Health Affairs and Chief Medical Officer" pursuant to Sec. 872 of the Homeland Security Act. The addition of "assistant secretary" to the title establishes the standing of the CMO within the DHS hierarchy

and other agencies. From a protocol standpoint, the designation of the Chief Medical Officer as an assistant secretary is important to facilitate interagency communication and cooperation among the Office of Health Affairs' cognate offices in other Departments, each of which is headed by an assistant secretary. The designation of the CMO as an assistant secretary is also entirely consistent with Sec. 612(a)(3) of the Post Katrina Act, which elevated the Chief Medical Officer to the level of an assistant secretary in terms of Executive Schedule compensation.

b. What is the statutory authority for creating this position?

The Secretary of Homeland Secretary has plenary authority under Sec. 102 of the Homeland Security Act which provides that the Secretary shall have direction, authority, and control over the Department. The position of Chief Medical Officer was originally created upon notice to Congress in July 2005, as part of the Secretary's "second stage review" under Sec. 872 of the Homeland Security Act. Congress later codified and articulated the responsibilities of this position in Sec. 516 of the Post Katrina Act (P. L. 109-295). Section 516 of the Post Katrina Act states that the Chief Medical Officer is to be appointed by the President with the advice and consent of the Senate. Congress also indicated its intent to elevate the position to the assistant secretary level by setting the Chief Medical Officer's compensation as Executive Schedule IV, making the CMO equivalent to other assistant secretaries within the executive branch.

In January 2007, following enactment of the Post Katrina Act, the Secretary again notified Congress pursuant to his reorganization authority under Section 872 of the HSA that "DHS will create an Office of Health Affairs (OHA), which will report to the Secretary through the Deputy Secretary. The CMO, who will lead the office, will have the title of Assistant Secretary for Health Affairs and Chief Medical Officer." Upon the expiration of the 60 day period for Congress to object under Sec. 872, the reorganization plan became effective and the Chief Medical Officer assumed the additional designation as Assistant Secretary for Health Affairs. It bears noting that this position was not created pursuant to Sec. 103(a) of the HSA. That section, which permits the appointment of not more than 12 presidentially-nominated and Senate-confirmed assistant secretaries, was not invoked here because Congress already authorized the CMO as a PAS position.

c. Does the position Assistant Secretary for Health Affairs carry with it any duties in addition to those laid out in the Post-Katrina Act? If so, what are they?

The duties of the Assistant Secretary for Health Affairs and Chief Medical Officer are consistent with the duties outlined in the Post-Katrina Act and as provided for in the January 2007, Sec. 872 notice which designates this position to lead the newly created Office of Health Affairs. Also, please refer to my response to question 13a.

d. Are there any other duties not described in your answer to (c) for which you will be responsible as Assistant Secretary for Health Affairs, if you are confirmed?

The duties of the Assistant Secretary and Chief Medical Officer are described in full in Sec. 516 of the Post-Katrina Act and the January 18, 2007 Sec. 872 notice to Congress. My response to question 13a includes the overall responsibilities of the Assistant Secretary and CMO. However, the Secretary reserves the right to assign duties to offices in DHS as the needs arise.

e. Will the additional duties you have described detract from your ability to perform the duties prescribed in the Post-Katrina Act?

The additional duties, personnel and budget enhance the Assistant Secretary's ability to perform all of the authorities granted under the Post-Katrina Act. As a result, I do not believe the additional duties will detract from my ability to perform the duties prescribed in the Post-Katrina Act.

14. In your view, what are the major internal and external challenges facing DHS and OHA? What have you done to address these challenges? Are there any current or future plans to address these challenges?

Internally, bringing management discipline to a new organization within a new organization is extremely challenging. Identifying a mission that had not been addressed necessitates growth of the organization. This condition is not unique to OHA, but is common to other very important programs at DHS with whom we must share resources. Making a strategic plan, identifying goals, objectives and metrics and receiving congressional authorization was much easier than identifying the resources to meet the mandate given to us. The large increase in mission space and responsibility we have already assumed has put a strain on our workforce, which can only be addressed by building the staffing levels necessary to meet these mandates. We have made a lot of progress in our first seven months as the OHA, and we are on target in FY08 to bring our staffing to a level to ensure that OHA is effectively carrying out its mission.

Externally, we face the same challenges as the broader DHS. Our role is to coordinate a broad range of talent and resources that Federal, State, tribal and local government agencies and the private sector possess. Much of that resource pool was not and is not coordinated in a way that brings its strength to bear for preparedness, response and recovery from catastrophic incidents. There has also been confusion as to "who's in charge" of the preparedness for, response to and recovery from incidents of various levels of significance. Our new "coordinating" agency has challenged relationships that have been heretofore ineffective for the homeland security mission, and have attempted to bring disparate elements together at the planning table.

The OHA is committed to this collaboration and coordination by demonstrating that our presence adds value to the mission, and so far that has been largely well received. While the demand has been high for entrée into DHS by numerous

stakeholders who had not previously been "invited to the DHS dance," our ability as a small office to satisfy the demand has been extremely challenging. As we establish a firmer constituency, involving them in interdisciplinary planning and policy activities will tap into their talent and resources so that everyone's strengths can be put to best use for the benefit of the Nation.

15. What do you see as the principal mission(s) of OHA?

The OHA serves as the Department's principal agent for all health security matters. Working throughout the Federal interagency and with the private sector, the Office leads the Department's role in developing, supporting, measuring and refining a scientifically rigorous, intelligence-based medical and biodefense architecture to ensure the health security of our Nation.

16. What do you see as OHA's principal strengths and weaknesses in its ability to accomplish those mission(s)?

The principal strengths are the qualified, dedicated, and professional career staff that comprises OHA, the strong support for OHA from the Secretary and the Deputy Secretary, and the immense amount of progress the staff has made in building programs, partnerships, and networks.

The primary challenges OHA will face include growing sufficiently to fulfill the mission in an environment of static or declining resources. An example of this growth is the need to create a successful regional presence to work with State and local homeland security and health professionals to achieve complete vertical integration with our bioterrorism planning and establishing seamless interagency relationships during the management of a catastrophic incident.

17. If confirmed, what would be your top priorities? What do you hope to have accomplished at the end of your tenure?

My top 4 priorities are:

1) To serve as the principal medical authority of DHS.
2) To lead the Department's biodefense activities to include policy, strategy, requirements, operational programs and metrics.
3) To develop a coordinated National biodefense architecture for WMD planning and catastrophic consequence management.
4) To ensure that DHS employees are supported by an effective Occupational Health and Safety program.

By the end of my tenure, I intend to leave my successor with an office that has made significant strides toward reaching the goals outlined above. I want to leave the OHA Biodefense office with a fully operational National Biosurveillance Integration

Center (NBIC), a BioWatch program to field automated pathogen detectors, a fully staffed and effective Office of Agriculture and Veterinary Defense, and an office that informs our nation's investments in medical countermeasures based on good science and intelligence. I intend to leave a Medical Readiness Office that is capable of orchestrating the strategic planning process for the biological planning scenarios, setting guidance for the Department's grants related to health preparedness, has plans and a budget in place to achieve a robust regional presence to help coordinate emergency management and the health sector in planning and incident management for incidents human and biological consequences, and provides support to medical first responders who are on the front lines of these incidents. I intend to leave an Office of Component Services that will give the Department unified policies, standards, and metrics for occupational health and workforce protection, and to support the components in all health and medical matters.

IV. Policy Questions

18. How will OHA support DHS' major mission and management areas, including Emergency Preparedness and Response, Critical Infrastructure and Key Resources Protection, and Science and Technology?

The OHA is authorized as the principal advisor to the Secretary of DHS and to the Administrator of FEMA on all health and medical issues. In this role, OHA leads and supports all DHS activities with regard to health preparedness, including planning and response to catastrophic incidents with human or biological consequences. The OHA also supports all other components and headquarters functions, including Infrastructure Protection. OHA is a major customer of the Science and Technology Directorate's Chem-Bio division, and serves as the co-chair of the Chem-Bio Integrated Product Team to set requirements for science and technology development particularly in the biological and chemical areas.

The responsibility for emergency preparedness and response activities with OHA are largely under the aegis of the Office of Medical Readiness (OMR). OMR serves as the coordinating center for medical and health related preparedness and response activities for DHS. Its mission is to reduce the vulnerability of the American public to all hazards by ensuring that there is a well coordinated, effective and efficient structure that integrates all elements of emergency management including health preparedness issues to prepare for, respond to, and recover from natural and man-made disasters.

The OMR supports DHS' major mission and management areas through the following specific activities:

1) Ensuring the existence of strategic, end-to-end national plans for the biological planning scenarios and supporting the integration of intra-agency and interagency all-hazards consequence planning, exercises, training, and response;

2) Increasing the DHS knowledge base on the health consequences of all hazards;
3) Coordinating medical readiness activities within DHS and with interagency partners such as HHS;
4) Providing the Department's medical incident management during catastrophic events;
5) Promoting and supporting the integration of local and regional medical response and emergency management capabilities;
6) Synchronizing medical and health preparedness grants within DHS and with its interagency partners (e.g. HHS); and
7) Support the medical first responder community.

Under HSPD-5, a major role of DHS is interagency incident coordination. Importantly, this does not mean managing each of the various emergency support functions (ESFs) that are required under the National Response Framework, but instead, coordinating across ESFs and Federal agencies, and with all levels of government including Federal, State, local, and tribal.

Health and medical services are essential components of any incident response, and ESF-8 is devoted to the carrying out of these services. Providing services related to ESF-8 is the sole responsibility of HHS. Before the creation of OHA there was no entity that was specifically responsible for advising the Secretary and the FEMA Administrator about the activities of ESF-8 or their interactions and effects on other DHS responsibilities, or to serve as a facilitator for HHS' requirements to fulfill its mission. During an incident in which the ESFs are activated, HHS provides the expertise and operations necessary to provide patient care and other public health and medical support for the incident. OHA is responsible to the Secretary of Homeland Security for ensuring that DHS' interest in this function is addressed, while serving as the Department's liaison to HHS and assisting HHS with situational awareness and with requirements not handled by the National Response Coordination Center (NRCC).

In an agricultural or veterinary health emergency, OHA serves the same function for ESF-11 and the USDA. In this case, our Food and Agriculture Defense Office coordinates with OMR to provide subject matter expertise and operational awareness to the NOC and USDA, and provides a liaison function to assist USDA with its requirements not handled by the NRCC.

19. The OHA has assumed responsibility for biodefense, Weapons of Mass Destruction (WMD) public health preparedness, medical readiness, and workforce health protection. Can you describe your goals in each of these areas?

WMD and Biodefense

The Office of WMD and Biodefense is where we have consolidated DHS programs in the biodefense mission space. Specifically, its goals are:

1) Provide early warning of an aerosolized biological attack on high-threat metropolitan areas. Numerous models have shown that delays in delivery of medical countermeasures to an affected population after a biological attack result in a significant increase in morbidity and mortality. Our BioWatch program is constructed to detect such an attack within as short a time as possible, and in coordination with the public health and law enforcement communities to guide the triggering of countermeasure delivery.
2) Provide comprehensive knowledge of worldwide health events and trends. Through long-term medical surveillance we may detect health event anomalies above the background threshold. Through the building of the National Biosurveillance Integration Center (NBIC) we are building the IT and human resources required to gather this information in near real-time, analyze it for homeland security relevance, and report it to the appropriate senior leaders.
3) Enhance protection of our agricultural resources and production capacity. Primarily, this entails building functional relationships with Federal, State, academic, and private entities to assess current capabilities and vulnerabilities. Secondarily, this entails an overarching planning function to define the coordination that take place during an event.
4) Threat analysis and countermeasures. Working closely with the Science & Technology Directorate, we drive requirements and assist S&T with defining biological and chemical threats to our population, which informs the BioShield countermeasure process. This risk assessment is currently being expanded from a biological risk assessment that included selected chemicals into a fully integrated risk assessment across the CBRN spectrum. Improvements in threat analysis and population risk assessments will better guide our participation in Project BioShield. Under the leadership of the Department of Health and Human Services, we participate in the governing board of the BioShield enterprise, and we co-administer the BioShield Special Reserve Fund. BioShield is intended to streamline the development, acquisition, and approval processes and provide the most effective countermeasures to the Strategic National Stockpile.

Medical Readiness

The Office of Medical Readiness (OMR) serves as the coordinating center for medical and health related preparedness and response activities for DHS. Its mission is to reduce the vulnerability of the American public to all hazards by ensuring that there is a well coordinated, effective and efficient structure that integrates all elements of emergency management including health preparedness issues to prepare for, respond to, and recover from natural and man-made disasters.

The OMR supports DHS' major mission and management area through the following specific activities:

1) Ensuring the existence of strategic, end-to-end national plans for the biological planning scenarios and supporting the integration of intra-agency and interagency all-hazards consequence planning, exercises, training, and response;

2) Increasing the DHS knowledge base on the health consequences of all hazards;
3) Coordinating medical readiness activities within DHS and with interagency partners such as HHS;
4) Providing the Department's medical incident management during catastrophic events;
5) Promoting and supporting the integration of local and regional medical response and emergency management capabilities;
6) Synchronizing medical and health preparedness grants within DHS and with its interagency partners (e.g. HHS); and
7) Supporting the medical first responder community.

The OMR is composed of five divisions that serve to accomplish the goals of the Medical Readiness Program. These include: Incident Planning, Emergency Management and Medical Readiness Integration, Grants Coordination, Incident Management, and Medical First Responder Coordination.

Workforce Health Protection

The OHA responsibility in protecting the DHS workforce is a subset of our role in occupational health and safety. Our goals are to:
1) Ensure our workforce is medically ready for daily response duties,
2) Ensure the availability of medical response for DHS employees during contingency missions.

OHA has a significant role, in conjunction with the Management Directorate's Office of Safety and Environmental Programs (OSEP) and the components' safety offices for these DHS functions. OSEP has the additional responsibility to minimize safety risks during those missions.

The OHA Office of Component Services hired a Director of Force (workforce) Health Protection and Wellness in September 2007, and is in the hiring process for a Director of Occupational Medicine. Their closely linked roles will be to coordinate with the components to ensure that occupational health principles are incorporated into the job "life-cycle" of all appropriate DHS personnel, especially responders, to ensure coordinated policies and standards for issues such as duty-based physical standards, pre-placement physical evaluations, periodic physical evaluations, and pre-response medical preparation.

The OSEP has the lead for all safety programs, including those related to response operations. Through a MOA with the Office of Safety and Environmental Programs (OSEP), OHA will function as a major partner in these safety operations through adding medical/scientific basis to recommendations and providing a senior-level, "third party" voice for safety controls in operational environments.

20. What is the expected course of action and timeline for milestones for the establishment of unified Occupational Health and Safety regulations across the entire DHS workforce? What are the major challenges in effecting these changes?

The establishment of unified Occupational Health and Safety Regulations is a joint effort between OSEP and OHA. Under DHS Management Directive 5200.2, currently in final approval, "It is DHS Policy to establish and maintain an effective and comprehensive safety and occupational health program, which is consistent with the standards promulgated under the Occupational Safety and Health Act of 1970, E.O. 12196, and 29 CFR Part 1960." Under this memorandum, the role of the Assistant Secretary for Health Affairs is to serve as the primary policy advisor to the Secretary, Under Secretary for Management, and the Designated Agency Safety and Health Official (DASHO) on occupational medicine aspects of the safety and occupational health program.

With the seniority of an Assistant Secretary and with the subject matter expertise of a physician, I will be well positioned to establish scientifically and medically valid policy, requirements, standards, and metrics that will serve to drive synchronization, standardization, and unification of occupational safety and health (OSH) policies and regulations across the Department. Over the next fiscal year, we will catalog existing OSH programs within the Department and benchmark these against best practices in industry. Our goal is to complete this process over the fiscal year and, in conjunction with OSEP, reach 50% development of unified DHS OSH policies and regulations this year, laying the ground work for a complete program by the conclusion of the next fiscal year. The major challenge in accomplishing this goal will be the varied missions of the Department's components which will require establishing a firm scientific and "best practices" basis in order to convince component leadership to adopt common policies and procedures except in those areas where unique missions dictate unique approaches.

21. The Government Accountability Office (GAO) and others have identified a serious lack of clarity among agencies in the Executive Branch regarding roles and responsibilities for preparing and responding to disasters. It will be essential that OHA effectively coordinates with other Departments and agencies, including the Departments of Health and Human Services (HHS), Defense, and Veterans Affairs.

a. How will you and your office develop partnerships and coordinate with other Federal agencies?

The lack of clarity that exists is often due to the confused parties not having read such documents as the National Response Plan or the new National Response Framework or subscribing to their tenets. Since coming to DHS in 2005, I have witnessed tremendous progress in that area, driven by Federal entities participating in the exercises to reach that clarity and by events that have demonstrated the value of adhering to a defined response methodology.

Within the structure delineated by the National Response Plan and the National Response Framework, each department and agency has clearly defined roles and responsibilities for preparing for and responding to disasters. The Office of Medical Readiness will incorporate planning, grant coordination, and response functions into a broad cooperative effort across the interagency to include HHS, DoD, VA, and all relevant agencies. The Office recognizes that it will require coordinated interagency functions to accomplish its stated goals and objectives. This coordination will require the continued development of relationships being fostered by all members of the OHA team.

My senior staff and I personally meet with our counterparts in partner agencies on a routine basis. We conduct a weekly conference call with the Office of the Assistant Secretary for Preparedness and Response (ASPR) at HHS and our staff meets many times per week on collaborative projects with the ASPR staff. Key members of the OHA staff are commissioned officers in the US Public Health Service working with us on detail. We also helped to establish the HHS seat in the National Operations Center (NOC), which is adjacent to the OHA desk in the NOC. Finally, we will actively engage partner agencies in the formal planning process with the Incident Management Planning Team (IMPT) in the Operations Directorate. The operational plans resulting from the strategic planning effort depend on buy-in from other Federal agencies. An example of this is that HHS has a member of the IMPT who participates as a key member of the Pandemic Influenza Planning Team and the Pandemic Border Management Planning Team. This enables HHS to perform departmental operational planning that is fully articulated with the National strategic plan for pandemic flu.

b. What partnerships and coordination have already been developed?

Much of this is answered above. Other examples follow:

The Office of Medical Readiness works on a daily basis with partners from HHS, VA, DoD, and others to prepare for catastrophic incidents. Our grants coordination division is heavily engaged with FEMA and HHS to continue the process of harmonizing and coordinating the grant guidance and timetables. Through our pandemic influenza planning and preparedness functions we are defining a broad set of partnerships with HHS, DoD, VA and other agencies in order to satisfy our obligations as defined in authorizing language and particularly related to HSPD-5. We intend to use these mechanisms as we proceed with planning across the biological and other scenarios.

Through the National Biosurveillance Integration Center (NBIC), we have signed formal memoranda of understanding/agreement with the Departments of Defense, Agriculture, HHS, Interior, State, and Transportation. These MOUs were promulgated primarily to facilitate the sharing of medical surveillance information and will also serve as the basis on which to share personnel as well. Additionally, the program is inextricably linked with counterparts within DoD and the US Postal Service regarding bio-detection systems.

The Office of Component Services also is dependent on interagency collaboration. As examples:

- Issues related to formaldehyde in travel trailers were managed through a liaison between OHA and CDC.
- OHA coordinated the development of procedures for CDC to coordinate with DHS on issues related to travelers with infectious diseases.
- OHA facilitated the transfer of the Immigration Health Service from HHS to DHS and crafted an MOU for the use of US PHS officers in the DHS workforce.

c. What information sharing strategies will you employ?

Vital to the awareness and management of incidents is for relevant Federal agencies to have a common operating picture of an event as it unfolds and is managed. The OHA has the responsibility, through its NBIC to provide a Biological Common Operating Picture (BCOP), so that HHS, USDA, DoD, Interior, State, and the intelligence community know what the interagency knows about biological events. We are building the IT and human resources required to populate the BCOP as the Center stands up fully by the end of FY08.

We are also working with willing private sector and State partners to supply the NBIC with data that is not currently part of any Federal data set. This includes poison control data, over-the-counter medication sales, and information from various entities through the National Infrastructure Coordinating Center (NICC).

Another important role for OHA will be to serve as the DHS representative to the Office of the National Coordinator for Health Information Technologies (ONCHIT). Through participation in the activities of ONCHIT, the Federal Health Architecture, and the National Health Information Network, OHA will help ensure that DHS and health architectures are compatible for issues such as medical services during a disaster or mass-migration event and for sharing of information related to bio and chemical surveillance.

d. What role will the OHA WMD Incident Coordination position fulfill? How will those responsibilities differ from those of FEMA or HHS in the response to a WMD event?

In accordance with OHA's authorization, we will serve as the advisor to the DHS Secretary and the Administrator of FEMA on all health and medical issues. The WMD Incident Coordination Division will maintain situational awareness of an entire incident and the spectrum of medically-related response in accordance with the requirements of HSPD-5 in order to discharge this duty to the Secretary and the Administrator.

HHS has the lead for public health and medical response to a WMD event as dictated by the National Response Plan's ESF-8. OHA provides the link from HHS to DHS as

a supporting agency to ESF-8. FEMA's response mission includes emergency management. OHA provides the health and medical guidance to FEMA in their response to a WMD event as dictated by the Post Katrina Act.

e. Do you believe that OHA has the necessary authority to carry out the Emergency Management and Medical Response Integration function represented in its organizational chart? How will this capability be implemented?

OHA has been granted authorities that provide both specified and implied requirements for the Emergency Management and Medical Response Integration function. Acquiring the resources to implement the authorities is working its way through the normal budget development processes.

22. How do the responsibilities of your WMD contingency planning office differ from, and support, the planning activities of FEMA and the Incident Management Planning Teams in the Operations Coordination Directorate? How do you coordinate these efforts with each office?

DHS is responsible for developing national plans for management of the 15 national planning scenarios to coordinate capabilities-based planning from end to end -- from initial threat through physical, environmental, and psychological recovery. The OHA is responsible for ensuring that there are national end-to-end plans in place for the biological planning scenarios – attacks by anthrax, pneumonic plague, foot and mouth disease, food-borne pathogens and pandemic influenza.

These strategic plans will take advantage of expertise from the interagency and, in some cases, State and local health officials and the private sector. The national strategic plans will define the roles and responsibilities of all the players who have a role in preparedness, response and recovery -- State, local and tribal governments and owners of critical infrastructures. From these strategic plans, Federal agencies will develop departmental operational plans and will define roles and responsibilities for their partner organizations and subordinate agencies.

FEMA-Preparedness has the responsibility for State and local contingency planning, and the Critical Infrastructure (CI) Partnership office works with CI owners on their contingency plans.

OHA's job in this planning process is two-fold: (1) to provide the strategic guidance, assemble the interagency subject matter expertise, and supply contract planners to the DHS Incident Management Planning Team who is responsible for writing the strategic plans for the biological scenarios, and (2) to advise FEMA-Preparedness on the preparation of the State and local plans for the biological scenarios.

Our WMD Contingency Planning office within OMR is responsible for supporting this mission for OHA. At each stage in the planning process, OHA will provide

subject matter expertise from the interagency, acting in support of the DHS Secretary and the FEMA Administrator.

To date, we have worked side-by-side with the IMPT and the interagency to develop plans and exercises related to pandemic influenza. We will utilize this experience to drive further planning for other key scenarios in a continuous process.

23. What is the current status of OHA's operational plans for catastrophic scenarios, from pre-event planning through recovery? What is your timeline for completing this work? What assurance can you offer this body, the Administration, and the American people, that we are better prepared today than we were in 2005?

We have made a commitment to the Secretary to have all of these plans and playbooks completed by September of 2008. This time line is now in jeopardy because of appropriations issues. The resources for this effort were to be provided by a reprogramming requested in April 2007 and the FY 08 budget for OHA. The President's budget requested $117 million for the OHA (including the transfer of BioWatch and NBIC to OHA). We were unable to secure the reprogramming from Congress until June 2007, which did enable us to fill one Federal employee position in the OMR Division of Contingency Planning to supervise the process. We are now operating under a continuing resolution with our FY 07 number of $4.9 million, so there is no money to support the program of work. Moreover, the Senate-passed FY 08 appropriations bill shorts the OHA by $3 million beneath both the President's budget and the House-passed mark. These are program funds needed to perform the important functions detailed in the OHA strategic plan, including giving the Nation plans for biological terrorist attacks.

As the plans for the biological scenarios are developed with the IMPT, they will begin to drive department and agency operational planning and be used by FEMA-Prep to drive State and local planning, training, and exercises. All of this effort hinges on the completion of the national strategic plans for these scenarios, which hinges on resourcing the responsible entities to do the work.

Each year since 2005 has seen improvement in coordination of planning for catastrophic scenarios. Now that the OHA exists, we have begun to participate in this process with our interagency partners. The creation of the IMPT and the National Planning and Execution System (NPES) by the DHS Operations Directorate and has created a standard Federal interagency planning methodology and structure. We are now working more closely with FEMA, the IMPT, and our interagency partners to improve preparedness at all levels of government and society. While there is much work left to do, these coordinated efforts, among many others, have continued to improve our preparedness since 2005.

The OHA was recently charged by the Congress through the DOD Emergency Supplemental Appropriations Act of 2007to develop a strategy for communicating protective action guidance to the public in the metro areas of the Tier 1 Urban Area

Security Initiative (UASI) regarding the detonation of improvised nuclear devices (IND) of various yields. We have been given sufficient funds to develop a science-based strategy in collaboration with the UASI areas, which we expect to present to the Congress in one year. We expect to be able to articulate our strategy with the recently completed draft of the 10-kt IND Plan developed by the IMPT in a way that could be used as a communications annex to the plan.

24. GAO has recently released a report calling for greater clarification of roles for responding to a pandemic influenza event. What role will OHA serve in a pandemic incident and how will it interact with the Principal Federal Officer and Regional Federal Officers for Pandemic Influenza designated by the Secretary?

The OHA currently leads DHS efforts related to pandemic preparedness. During a pandemic, OHA would continue to perform its key missions by serving as the principal advisor to the Secretary on health and medical matters, and to support DHS operational and headquarters components in the fulfillment of their missions. OHA would also continue to serve in representing DHS in interagency policy and planning activities and to coordinate interagency activities into overall planning priorities. OHA would also provide real-time support on DHS issues to the National PFO, her support staff and the Senior Health Official from HHS in the National Joint Field Office. This activity is part of the ongoing process of close working relationships already developed between OHA and the pre-designated National PFO, including involvement in joint planning, training, and exercises.

It should be clear that HHS, not DHS, is responsible for patient care issues during a pandemic, to include hospital surge capacity issues, antiviral and vaccine procurement and distribution and recommendations for personal protective equipment and community mitigation strategies. DHS-OHA acts to support HHS in these responsibilities by getting the cooperation of public safety, emergency management and owners of critical infrastructures.

25. HHS oversees activities and grant funding in the areas of medical and public health preparedness, as does OHA. Specifically, how will you ensure that OHA's Medical Readiness Office does not duplicate functions or activities at HHS? For example, how is OHA coordinating with HHS to review State and local pandemic influenza planning? How will OHA contribute to the establishment of measures and metrics to evaluate state and local efforts for public health preparedness?

This issue is of great interest to State and local stakeholders. We agree that improved coordination of grant processes can help to improve overall preparedness. The Chief Medical Officer has worked since the inception of the OCMO to coordinate with HHS and DHS Grants & Training (now in FEMA) grants funding for medical readiness. OHA and HHS have established a grants coordination steering committee whose function is to align and synchronize DHS and HHS grants programs. OHA has coordinated DHS pandemic influenza preparedness

requirements with appropriate representation to support HHS in the review of pandemic influenza State plans.

It is my position that we should base all medical readiness grants on requirements arising from the national strategic planning process and the definition of State and local roles and responsibilities. The plan should drive the requirements for training, equipment and exercises, and those requirements should drive the grant qualifications and guidance as well as the budget for the grants. All of this is contingent on our ability to have national, departmental, State and local plans, a deliberate planning cycle that requires investment of time and resources.

OHA and HHS-ASPR are working with the Association of State and Territorial Health Officials and State Homeland Security Advisors to ascertain from the end-users how the Federal government can provide better coordination of grants to meet their requirements. This may result in conforming grant guidance, timing of grants or legislative proposals to reduce the impediments to efficient use of health preparedness grant funding by State and local governments.

26. One of the public health assets under the direct jurisdiction of DHS is the Metropolitan Medical Response System. What steps are you taking to leverage this program to address local preparedness planning? Do you intend to work with member jurisdictions to identify a core mission statement, minimal mission capabilities, a system of measures and metrics by which to gauge their performance, and to develop a five year outlook for the program?

OHA has met with the leadership of many MMRS jurisdictions, both in Washington and on their home turf, and will continue to engage MMRS jurisdictions through the new Division of Emergency Management and Medical Response Integration in OMR. Currently, OHA is not the authorized entity at DHS with responsibility for MMRS. OHA will continue to attempt to work with FEMA to drive requirements for local medical readiness based on good science and best practices.

MMRS jurisdictions look to OHA for advocacy and guidance. They are eager to participate in the contingency planning process with their interdisciplinary partners at the local level, and are eager for the Federal government to define best practices. OHA is committed to being as active as we can be in working with those partners in coordinating and expanding the roles that MMRS programs play in local and regional planning coordination and integration.

27. In your March 29, 2007 statement to the House of Representatives Committee on Appropriations, Subcommittee on Homeland Security, you noted that OHA would develop a 5-year strategic plan with goals, objectives, milestones and measures.

a. What is your timeline for completion of this plan?

The OHA strategic plan is a living document that currently exists and evolves as OHA roles and responsibilities continue to expand. The plan currently in place reflects our goals for the first two years as the Office of Health Affairs. The next version of this plan, the 5-year strategic plan is being constructed to reflect current environmental and political conditions with corresponding adjustments to milestones and measures. This plan is scheduled for completion by the 2nd quarter of FY08.

b. How will OHA involve your partners in developing and executing your strategic plan?

The OHA works with our partners on a daily basis. Their input on all aspects of health security is woven into our strategic and operational planning.

c. Can you provide an example of the measures you would consider for assessing medical readiness of Federal agencies?

Development of medical readiness measures is part of our strategic planning process. We are actively engaged in exercise programs, including post-exercise evaluations, a method of measuring medical readiness. These exercise programs build from plans developed through an interagency process, training from those plans, and then work at all levels to exercise those plans in order to identify gaps and refine plans through a deliberative process.

Much of our current planning has focused on the threat of pandemic influenza. Exercises of these plans are scheduled over the next six months, including a State Department exercise for international and border issues (October 2007), a communications exercise that will drill our ability to communicate among Principal Federal Official group and the States, and interagency exercises at the assistant secretary and principal levels.

The ability of departments and agencies to perform their missions in these situations will serve as measures of overall readiness. As stated above, the foundation of this activity is the existence of horizontally and vertically integrated plans that will drive resource and budget requirements for the Federal agencies' health preparedness and grant requirements for the sates and local communities.

28. How will you communicate with State and local jurisdictions so they can understand how OHA's roles and functions are aligned within the National Response Plan and its forthcoming revision, the National Response Framework?

The OHA external outreach to States and local officials is not nearly as robust as it needs to be. Most of my time over the past two years has been focused on staying home and managing the day-to-day operations of the new office and participating in the plethora of meetings each week at which OHA must be represented. I intend to leave my successor an organization that is better staffed and equipped to carry on the tasks of management, policy coordination and interagency collaboration at levels

other than an Assistant Secretary, so that he or she can lead the external outreach and be a more effective ambassador for the Department and the Secretary.

Much of this can be addressed by filling out the organizational chart with a regional footprint. In our strategic plan and on our organizational chart, we have the Division of Emergency Management and Medical Response within the Office of Medical Readiness to realize that connection with State and local officials, as noted above in Question #10. We have budgeted sufficient funds in FY08 to provide core staff for the division to begin the long process of outreach with the regional, State and local emergency management and health officials.

Even though we do not yet have a regional footprint, our OHA staff is in frequent contact with State and local officials around the country. We do this through invitational speaking engagements and meetings with key public safety and health officials around the country, as well as spending a lot of time on the phone. The small size of our staff and budget has limited the scope of this outreach, but we have been as aggressive as we can given those limitations. We are also building an informative Web page with my public remarks and organizational structure.

Implementation of the Post-Katrina Act

29. The Post-Katrina Act reorganizes aspects of DHS to enable the Department to more effectively fulfill its emergency management mission.

a. If confirmed, what would be your priorities in overseeing the implementation of the Act?

The OHA has a number of priorities for the implementation of the Post-Katrina Act. One is ensuring internal and external coordination of all medical preparedness and response activities of the Department, including training, exercises, and equipment support and serving as the primary point of contact with other Federal Departments on medical and health issues. We have developed excellent working relationships with other DHS components and agencies and with our interagency partners, especially with HHS.

We are actively working within DHS and with our interagency partners to provide guidance and subject matter expertise in the health preparedness grant guidance as well as the MMRS, which was moved to FEMA. We have been actively engaged with the Homeland Security Exercise and Evaluation Program to ensure that appropriate medical and health issues are addressed in the planning, execution and evaluation of all Federal exercises.

One important role given to OHA in the Act is to serve as the medical advisor for the FEMA Administrator. We have fulfilled this so far in two key ways: (1) by providing scientific guidance and coordination with CDC, NIOSH and OSHA on the travel trailer formaldehyde issue, and (2) by staffing the National Response Coordination

Center (NRCC) during TOPOFF 4, the recent government-wide exercise, as well as any real disasters in the future, to ensure that the Administrator's and the Secretary's health security equities are addressed by the ESFs. This also provides visibility for the OHA Watch Desk into emergency support functions to keep senior OHA management informed and enables OHA to support HHS in their role as lead of ESF-8 and USDA as lead of ESF-11.

b. What do you believe is your role in the implementation of the Act, and what steps have you taken as Acting Assistant Secretary for Health Affairs and CMO to implement the Act?

We have taken the authorities that Congress gave us and devised a strategic plan and used four of the five authorities as the four goals of the OHA. Those four goals form the basis for all of the OHA's objectives and metrics. The Secretary used the opportunity of the reorganization of the Preparedness Directorate to create the OHA and place it in the organization where it could exert its cross-cutting authority.

c. In your view, what role would the Assistant Secretary for Health Affairs and the CMO have in emergency situations under the Act?

Consistent with current authorities, the Assistant Secretary will serve as the principal advisor to the Secretary of Homeland Security and the FEMA Administrator on all health and medical issues. Specifically, this office will assist the Secretary by providing guidance and analysis related to response options and resources needs in developing a coordinated strategy across multiple disciplines. This responsibility starts with contingency planning, driving requirements for grant-funded equipment and training, exercising and revising plans. One of the keys to providing successful incident management support during an incident is having a well-drilled plan to follow.

OHA stood up a 24/7 Watch Desk within the NOC. The OHA desk has direct feeds from NBIC and BioWatch. During biological incidents, the NBIC interagency group will stand up as a current operations crisis planning group in support of the DHS Crisis Action Team to provide interdisciplinary subject matter expertise.

OHA will provide staff for the NRCC during emergency situations to ensure that the Administrator's and the Secretary's health security equities are addressed by the ESFs. This also provides visibility for the OHA Watch Desk into emergency support functions to keep senior OHA management informed and enables OHA to support HHS in their role as lead of ESF-8 and USDA as lead of ESF-11.

The Office will also fulfill its responsibilities to directly support DHS components in monitoring and supporting the health needs of their workforce. The OHA Watch Desk will be the focal point of contact for Federal and non-Federal entities regarding medical and public health matters, per the strategic plan and our congressional authorities.

d. What are the policy and operational strengths and challenges of the new alignment from your perspective?

The transfer of the preparedness function into FEMA will potentially increase our communications challenges and ability to drive grants requirements for medical preparedness, when compared to our position within the former Preparedness Directorate. We are working to overcome those challenges by becoming an important service organization for FEMA through our Component Services and Medical Readiness offices, supporting FEMA operationally and participating jointly in planning and exercises.

30. What management challenges do you foresee in the implementation of the Post-Katrina Act? What are your plans to overcome these challenges?

The scope of responsibilities outlined for OHA in the Post-Katrina Act represents a vital set of functions and responsibilities related to the nation's homeland security, which cut across the entire Department. The largest management challenge is in having a huge mission but a very small number of people and resources. Our ability to deliver services to departmental components is therefore limited to our numbers and our creativity in leveraging other resources. As soon as we turned on the lights at OHA and put out the "open" sign, we were deluged with demand for services.

My strategy has been very simple: To default to the answer "yes, we'll do it," in spite of demands on our OHA work force, until our budget and personnel catches up to our mission requirements. We must be proactive in engaging the department and components leadership to add value to their operations. We do this by providing medical "counsel" for planning and response and for all of the "pop up" issues that the Department faces constantly, as well as coordinating the requirements of DHS for and from the Federal health community.

31. In your view, what resources does OHA need to carry out its responsibilities under the Post-Katrina Act?

Our resource requirements are driven by our strategic plan. Our OHA leadership prioritized the elements of the plan and their fiscal requirements for the Department's budgeting process.

The FY09 budget process provides the first opportunity OHA has had to align our strategic plan with its resource requirements. In the internal DHS deliberations over this resourcing, I have received outstanding support for the strategy and planned programs. At this point in the process, the resource allocations, if they remain in place through the OMB, authorization, and appropriation processes, will allow us to implement the strategy we have developed to meet our responsibilities to the department and the nation.

32. The CMO is responsible for programs to ensure the health and safety of DHS employees during their response to emergencies and disasters. While the CMO's responsibility does not explicitly extend to other Federal workers, or to other responders in general, the CMO nonetheless was given the responsibility in the Post-Katrina Act to serves as the principal advisor for medical and public health matters to the DHS Secretary and the Administrator of the Federal Emergency Management Agency, and as DHS' primary point of contact for State, local, and tribal governments.

a. What steps have you taken as Acting Assistant Secretary and CMO to fulfill these responsibilities? If confirmed what additional steps, if any, will you take?

Support for DHS employees during response to disasters has three major components: Ensuring medical readiness for typical / daily response duties, ensuring availability of medical response for DHS employees during contingency missions and minimizing safety risks during those missions.

OHA has a significant role, in conjunction with OSEP and the components' safety offices for the first two portions of this, while OSEP has the lead for the third.

The Office of Component Services has recently hired a Director of Force Health Protection and Wellness, and is in the hiring process for a Director of Occupational Medicine. Their closely linked roles will be to coordinate with the components to ensure that occupational health principles are incorporated into the job "life-cycle" of all appropriate DHS personnel, especially responders, to ensure coordinated policies and standards for issues such as duty-based physical standards, pre-placement physical evaluations, periodic physical evaluations, and pre-response medical preparation.

The OSEP has the lead for all safety programs, including those related to response operations. Through an MOA with OSEP, OHA will function as a major partner in these safety operations through adding medical/scientific basis to recommendations and providing a senior-level, "third party" voice for safety controls in operational environments.

In addition, OHA has established a relationship with FEMA and the FEMA Administrator. Most notably we have provided subject matter expertise to FEMA for their investigation on the travel trailer formaldehyde issue, including issues associated with both trailer occupants and FEMA employees' potential exposure to formaldehyde and other substances.

We will continue to strengthen our service to all of the components as we enhance our occupational medicine capabilities. We are actively working towards providing a more uniform approach to occupational health for all DHS components, using best practices from across DHS and the Federal government.

A significant role of the Office of Component Service within OHA is establishment of an emergency medical services (EMS) section with 2 primary roles: (1) medical supervision of EMS services provided by or on behalf of the Department; and (2) establishment of policies, requirements, standards and metrics for EMS support of DHS operations. Funding for this office is dependent on funding the President's FY08 budget. The Senate-passed mark will not support this critical function. We currently have around 2000 pre-hospital medical providers in the Department providing care without a unified medical authority.

In the interim, my staff has coordinated with the components to catalog existing services and map gaps in medical supervisory support for EMS. We have hired an EMS coordinator and are in the process of hiring an EMS Physician Director, pending the FY08 budget. Their role will be to ensure that appropriate emergency response systems, either directly provided or established through local services, are in place and that they have the required medical supervisory structures, including protocols and back-up, to enable their efficient operation during both day-to-day and contingency operations.

b. What role will OHA have in assessing, monitoring, and guiding the safety conditions for DHS responders in a catastrophic incident?

This is explained in detail in the previous question. OSEP is the lead with OHA support. OHA has already developed a close working relationship to agencies such as NIOSH and the National Center for Environmental Health at the CDC. We use these relationships to leverage the collective industrial and environmental health capabilities of the Federal Government in assisting OSEP and the individual component safety offices.

c. What responsibilities does DHS, as the lead Federal agency for catastrophic incidents, have for the health protection of non-DHS Federal workers?

DHS has no statutory authority or any role in health protection standards for non-DHS Federal employees responding to a disaster. Federal departments and agencies maintain primary responsibility for the health protection of workers within their agencies. The Occupational Safety and Health Administration (OSHA) provides real-time guidance for worker protection during an incident.

d. In catastrophic incidents, which typically involve response personnel from multiple jurisdictional levels, what is the extent of Federal responsibility for the safety and health of non-federal responders?

Safety and health of non-Federal responders is the primary responsibility of their local municipality. Safety issues fall under the authority of OSHA, although some emergency service workers are exempt from OSHA rules. Under our strategic plan, we are standing up a division of Medical First Responder Coordination in the Office of Medical Readiness, which is created to support the needs of the EMS community

in responding to disasters. This office will be able to ascertain the requirements of this community for additional safeguards and standards that we can coordinate through other Federal agencies with appropriate authorities.

33. With respect to biodefense, can you describe how the operational components of BioWatch have been transferred into OHA and how you envision OHA carrying out this mission? What role will OHA play in the development of the next generation biowatch system?

BioWatch is now an operational component of our Office of WMD and Biodefense. The mission has not changed, except that, as a function of technology transfer from the Science & Technology Directorate (S&T), we have transitioned into a more operational focus. This focus is reflected in the BioWatch CONOPS development in three ways: (1) provide grant funding to local jurisdictions to operate the existing suite of bio detectors; (2) assist local jurisdictions in preparing their response options in the event of a BioWatch notification or "hit," and (3) ensure the integration of the DHS detector array with other Federal biodetection systems operated by the DoD and USPS.

With respect to the development of the next generation automated detectors, OHA is the customer of the technology development of S&T. OHA drives the requirement for automated detection to S&T, S&T develops the technology to a certain stage of development, and then OHA performs the operational testing in BioWatch jurisdictions. This operational testing involves acquiring adequate numbers of detectors, placing them in appropriate locations to optimize detection, validating their results against previous generation detectors, and working with the jurisdictions to ensure a seamless local-State-Federal response to a "hit" involving public health, law enforcement and environmental protection.

National Bio-Surveillance Integration System

34. DHS's Office of the Inspector General (OIG) recently released a report noting that the National Bio-Surveillance Integration System (NBIS) was falling short of its objectives. Specifically, the report noted the NBIS system to be: (1) lacking in leadership as a result of DHS' reorganization; (2) lacking adequate staffing, particularly in information technology; and (3) experiencing difficulties in coordination among agencies. What has been done to address the recommendations in the report directed to your office, and what is your timeline for doing so?

One of the first actions I took upon learning that the program would transition to the OCMO was to request that the DHS IG assess the current status of the program, including the information technology aspects. I wanted an honest appraisal of NBIS' history, capabilities, and identified problems before I took ownership of the program.

I detailed my Chief Scientist, one of only three Federal employees in the OCMO at the time, to act as interim director of NBIS to get the program on track and to assist the IG with his assessment. During this interim year, the CIO awarded the contract for

the development the software NBIS 2.0. Memoranda of Agreement have been signed with six Federal agencies regarding data sharing and roles and responsibilities. Interagency agreements are being finalized to bring detailees into the program from the interagency partners. The first detailee, from the CDC, is currently on board. The NBIC was authorized under the "911 Act." This is consistent with the change in direction that focuses more on the people and the relationships with the interagency partners than on "NBIS," the software system.

Unfortunately, the transfer of the program to the OCMO in September 2006 did not include any transfer of Federal FTE personnel billets from the Preparedness Directorate, causing a major staffing problem for the Center. The OCMO submitted personnel requirements through all the normal channels, and FTE became available after Congress approved the OHA reprogramming in June 2007. All positions have been advertised and will be filled as soon as possible. In September 2007 we received permission to recruit a permanent NBIC Director, a GS-15 position. That position is currently being aggressively recruited.

In May 2007, I brought aboard a recognized expert in medical epidemiology and biodefense to be Acting Deputy Assistant Secretary for WMD and Biodefense, the office under which the NBIC is placed. I have empowered him to take the necessary steps to address all of the remaining IG findings:

By December 2007

- NBIC will fully define the desired operational end state to ensure a unique, value-added product to key stakeholders and senior decision-makers. This product is anticipated to include a comprehensive daily report of new and on-going biological events, worldwide, with an analysis of their potential impact on U.S. homeland security.
- OHA Watch staff and in-house analysts/subject matter experts will provide real-time answers to follow-up queries regarding real or notional events. This service can best be provided by hosting knowledgeable, well-connected representatives from select Federal agencies, empowered to analyze available data and communicate finished analyses back to their parent agencies.
- Hold substantive meetings with DoD's Armed Forces Medical Intelligence Center (AFMIC) leadership regarding a closer partnership to leverage respective strengths. This will include the potential sharing of personnel, space, IT infrastructure, and information sources.
- Fully define our infrastructure and CONOPS needs to prevent the reinvention of existing surveillance and analysis functions and to complement existing resources. Rather than competing with existing capabilities (e.g., AFMIC), we will be major customers of those systems in order to provide our situational awareness products focused on homeland biosurveillance needs. We will accomplish a confirmation of the personnel, IT systems, space, and contractor support necessary to perform these unique functions.

By September 2008, NBIS will achieve full operational capability.

- Daily, interagency-coordinated, biosurveillance products for key stakeholders and senior decision makers summarizing global bio-events.
- Timely analyses, educated projections, assessments and situational awareness of emerging bio-events of potential national significance, all pointing toward a Biological Common Operating Picture (BCOP). The BCOP is defined as, "given any disease event or trend, an ability to understand potential national impacts and proactively advise senior leaders on necessary steps to protect the Homeland."

35. The OIG also noted that the contractor responsible for developing the NBIS 2.0 project will likely not meet the contract schedule and requirements due to a lack of guidance from DHS management.

    a. What steps are you taking to provide the contractor real data and requirement documents necessary to complete development?

       We are redefining the unique product that NBIS needs to be capable of producing based on the stated requirements of the partner agencies and the realities of the data that are available to them. We will very clearly communicate those needs to the contractor to ensure full operational capability. The initial step in this process is the revision of the NBIS Concept of Operations (CONOPS) document, which will provide additional guidance for the contractor in the short term and provide operational transparency for our partners in the long term. This will be complete and vetted in December 2007.

    b. Does OHA have the capacity and resources to manage technology development of this magnitude?

       Since the program's inception, we have relied on the expertise of the DHS Office of the Chief Information Officer for technical guidance and expertise. The Deputy Director of NBIC is personally managing the development of NBIS 2.0. The process of hiring Federal employee IT professionals is ongoing, having begun with the allocation of Federal billets in the 4th quarter in FY07.

36. What will you do to strengthen the functioning of the National Biosurveillance Integration Center (NBIC) to coordinate and integrate data from multiple Federal agencies and monitor intentional and naturally-occurring biological threats? Do you believe we can effectively gather and analyze real-time data relative to events or threats, such as a bio-attack or a threat to the agriculture and food sector? What is the expected timeline for the detail of personnel and the integration of available HHS, U.S. Department of Agriculture (USDA), Department of the Interior, Department of State, Department of Justice, and Department of Defense data?

    We will leverage the strengths of existing medical surveillance systems in the Federal government, primarily those of DoD-AFMIC, the Centers for Disease Control and Prevention (CDC), and the USDA. Other sources of data certainly exist, and will be brought into NBIS with time. NBIC will not seek to create systems that are redundant

with those already in place in other Departments and agencies. Rather, the uniqueness of NBIS is in the analysis of all available data sources to advise the DHS Secretary and other senior national leaders via the BCOP on the significance of health events to homeland security/defense.

We have signed MOAs with six partner agencies that will facilitate information and personnel exchanges. We expect to have a full-time detailee from the CDC within the next few weeks. USDA leadership expects to have at least one detailee aboard very soon. We are already a major recipient of information and analyses from AFMIC. We are leveraging their capacity for intelligence gathering and analysis, and are willing partners with us in our mission to provide senior leaders with the best possible biological situational awareness.

It is important to keep in mind that, practically speaking, there are no truly real-time disease surveillance data. Presently, there is a lag time of varying length between people becoming ill and surveillance systems becoming aware of those illnesses. As our various national surveillance systems get closer and closer to being 'real-time,' I will work to ensure that the NBIC is a "real time" recipient of the data.

37. Does OHA have a role in training and exercising emergency response providers and clinicians, who may be among the first to see victims of an attack, in order to raise awareness of aspects unique to a Chemical, Biological, Radiological, Nuclear, and Explosive incident?

HHS has primary responsibility for these activities. OHA is taking the lead in ensuring proper training and exercising of DHS-employed first responders to assure proper coordination with HHS' training and exercising of the larger healthcare population, as well as for our workforce safety.

38. Your office has been involved in the development of a system that would allow the identities and certifications of emergency response providers to be verified at incident scenes. HHS has been involved in efforts to verify the credentials of volunteer health professionals, allowing States that request State-to-State mutual aid to verify that out-of-state health professionals are currently licensed in the assisting state.

a. Has your office incorporated health professional verification into its emergency response provider verification system, or does your office plan to do so in the future?

Through the work of the Office of the National Capital Region Coordination (ONCRC) and FEMA, the development of a system for identification and verification of emergency response providers has begun. The technology has been identified, and we are working closely with ONCRC and FEMA to develop implementation strategies. HHS has been involved in these meetings and has been encouraged to line up its implementation of its ESAR-VHP program with the identified technology and implementation strategies.

b. How are you ensuring that such a program does not duplicate or conflict with HHS' efforts?

We are encouraging HHS to be actively engaged in the planning and implementation of this identification and verification system. We are not seeking to duplicate or conflict efforts but rather to standardize processes and technology with the ESAR-VHP program.

c. If your office does not intend to include health professionals in its emergency response provider verification system, are you working with HHS to develop the two systems in such a way that they complement each other?

Please refer to question 37b.

39. As the Lead office at DHS for HSPD-9, what is your office's responsibility in seeing that the directive is implemented at DHS and USDA? Has DHS, in coordination with HHS, USDA, the Attorney General, and the Environmental Protection Agency begun drafting a coordinated agriculture and food-specific standardized response plan as called for in the directive? If such a document is already complete, has it been incorporated into the revision of the National Response Plan currently underway? If not completed, when is the expected release date of the plan?

Given that overall responsibility for accomplishing the tasks in HSPD-9 was assigned to DHS, and that the Secretary assigned OHA to coordinate DHS biodefense (to include agro-defense) activities, OHA has been given primary coordination responsibility for implementing the elements of HSPD-9 across the Federal agencies.

Although the agriculture and food-specific standardized response plan is in early draft stages, we are working with our DHS-internal counterparts (e.g., FEMA, NPPD) and other Federal Departments (e.g., USDA, HHS, DoJ, and EPA) to assemble the substantive portions of that plan. This requires significant effort to coordinate and can not be done quickly or easily. If all goes well and all parties invest in the effort appropriately, we envision having the coordinated plan in late FY08 or very early in FY09.

40. A recent report indicates that the authorization for the Select Agent Program, which regulates pathogens that can be used in bioterrorism, is set to expire at the end of Fiscal Year 2007. Are there any mechanisms in place to continue protecting these pathogens while additional authority is considered? How does your office plan to ensure continuity of prevention programs such as this on a long-term basis, either across years, or across political administrations?

Congress provided for a collaborative role for DHS with respect to select agent controls. The Homeland Security Act amended the Public Health Service Act and the Agricultural Bioterrorism Protection Act to include a collaborative role for the Secretary of Homeland Security in the establishment of appropriate safeguard and

security requirements for the administration of the Select Agent program. In addition, section 302 of the Homeland Security Act further provides the Secretary with responsibility for collaborating with HHS and USDA in determining any new biological agents and toxins that should be listed as select agents.

We have been working with HHS, DoJ and USDA to further enhance the security of the Select Agent Program. We are working with HHS in a new joint task force to examine thoroughly the safety and security of the biological safety laboratories. DHS has also provided HHS and USDA with a threat-based bioterrorism risk assessment on the agents of greatest concern, primarily to inform Project BioShield acquisitions, but the information could also be useful for prioritizing select agent controls, in the spirit of Section 302 of the Act.

Tuberculosis Incidence

41. On October 18, 2007, news reports surfaced about a Mexican national infected with multi-drug-resistant tuberculosis (MDR-TB), Amado Isidro Armendariz Amaya, who was able to enter the U.S. despite a lookout being placed in the Customs and Border Protection (CBP) computer-based screening system and CBP generating a lookout bulletin. According to the Center for Disease Control (CDC), information about this case was provided to DHS through the Office of the Chief Medical Officer, now known as the Office of Health Affairs (OHA). Information about the Amaya case has been provided to the Committee in a piecemeal fashion and it is troubling that some of the information provided by DHS has been contradicted by other government sources. In particular, the Assistant Chief Medical Officer reported to the Committee that he could not provide the Committee with information about the flights that Mr. Amaya took within the U.S. after DHS was alerted to his health status. The CDC, however, stated that it had received Mr. Amaya's flight information from the Assistant Chief Medical Officer.

On Monday, June 4, 2007, you briefed the Senate Homeland Security and Governmental Affairs Committee on the actions taken by the OHA to coordinate efforts with other DHS components to detain Andrew Speaker before he re-entered the U.S.; however, you did not mention the Mexican national with MDR-TB who had entered the U.S. undetected 21 times in the seven weeks prior despite being on a CBP watchlist.

a. When were you and your office informed about the case of the Mexican national infected with MDR-TB who Mexican health officials were concerned might enter the U.S. through El Paso, Texas?

   OHA was first informed about this case during an HHS phone conference that Dr. William Lang, Associate Chief Medical Officer, was invited to monitor on April 30, 2007.

b. What information about this individual was initially provided to the OHA and who provided the information? Please provide a copy of this notification.

There was no official notification. Dr. Lang was informed on a conference call and informed me immediately after the call that he was working on an issue with CDC and CBP of a Mexican national with TB who may have been crossing the border. No more detail was necessary.

c. Did you ask if the information provided to you such as name and date of birth were verified with identity documents?

No.

d. When did you or anyone in your office determine that the name and date of the individual provided to you was incomplete or inaccurate?

Over the course of May, my staff was aware that there were identification issues that CDC and CBP were working to resolve. As every indication at that time was that the patient was compliant with his treatment, and as there was a border lookout in place which matched the name that was on all available records, we did not get involved. Instead, we focused on working with CDC and immigration attorneys to determine the best course of action to take to deny him entry while not harming the effective relationship with Mexican TB control authorities on the border. On May 22, 2007, CDC communicated to my office that they had increasing concerns that the person may intend to cross the border. We then took a much more active role in working with CDC to find alternative mechanisms to get definitive identification. These efforts bore fruit on May 31, 2007, when CDC-El Paso received a copy of the subject's border crossing card from the treating physician in the clinic, it provided a copy of the card to CBP-El Paso. CDC also provided the information to OHA, who in turn provided the information to the DHS National Operations Center (NOC).

e. Who informed your office that the individual's name was incomplete or inaccurate? When were you informed?

Please refer to my previous response. I do not know who specifically informed Dr. Lang about the Project Juntos physician's suspicions. I do not recall when Dr. Lang informed me, but it was likely the same day (May 22, 2007).

f. If an incomplete name and date of birth was given, what efforts did you undertake to establish a full and correct name and date of birth?

OHA did not take a significant role in identification issues until CDC informed us that the treating physician became suspicious that the patient had violated his agreement with the physician not to travel. At this time, we worked actively with the Quarantine Medical Officer (QMO) to get additional identifying data for the patient through the Project Juntos physician.

CDC's Division of Global Migration and Quarantine (DGMQ) developed a strategy that the Project Juntos physician, who did not see patients in the clinic on a daily

basis, would talk to the patient during his next physician visit the following week. During this visit, the physician would emphasize to the patient that if he did not cooperate with the U.S. Government by providing accurate identification information, he ran the risk of losing his legal border crossing card (BCC) over the long-term, even if he became non-infectious. The patient then turned over his BCC to the Project Juntos physician. A copy of the document was then provided to CDC-El Paso, which then passed it on to CBP-El Paso. CDC also provided the information to OHA on May 31, which in turn provided the information to the DHS National Operations Center (NOC).

g. Did you or your office provide information about the about the Mexican national to CBP? If so, what information did you provide and when?

   Please refer to my previous response.

h. When did you and your office receive updated and accurate information about the individual's name and date of birth?

   May 31. Please refer to my response to question f.

i. Did you or your office provide the updated and accurate name and date of birth to CBP? If so, when?

   Please refer to my response to question f. CDC gave the information to CBP and OHA on May 31.

j. When did OHA provide information about the Mexican national to the Transportation Security Administration (TSA)? Was this information updated, and if so, when?

   On May 31, 2007, the DHS National Operations Center (NOC) was notified by OHA that the individual's full name and DOB had been obtained through a copy of his BCC, supplied to OHA by the CDC. The NOC, in addition to CDC-El Paso, notified CBP on May 31, 2007. TSA was notified about the Mexican national on June 1, 2007 through the NOC. TSA subsequently received updated information on June 4 and June 7 through the NOC. On June 7, 2007, CBP Headquarters Office of Field Operations (HQ-OFO) confirmed with Transportation Security Operations Center that they had received information on the subject.

k. If there was a delay in providing information to TSA from the initial report of the individual's name provided from CDC to OHA, please explain the cause for the delay.

   There was no undue delay in providing the information to TSA. The initial DHS response to CDC's request for assistance regarding the Mexican national was focused on the potential health threat posed by a border crossing at the El Paso Port of Entry. Based on the circumstances of the case, including the limited scope of the

individual's expected travel, CDC and DHS concentrated on intercepting the individual at a land border crossing. While CDC and OHA discussed ways to prevent the Mexican national from flying into the United States, there was no clear identification information on which to take action. Therefore, TSA's involvement was not requested at that time.

On June 1, TSA was provided information on the situation, just as were all appropriate Federal partners with a presence in the NOC. At that time, CDC did not make a request to take action against his ability to board an aircraft. Over the course of the following week, as additional data was learned, CDC, in coordination with DHS, determined that despite the surrender of his border documentation, his name should be included on the "Do Not Board" list.

l. How much time passed between the time OHA received initial information about the individual and the time TSA was provided the name of the individual in order to place him on the TSA "no board" list? If there was a delay, please explain why.

Please refer to my response to questions j and k.

m. How much time passed between the time OHA learned of the complete name of the individual and the time TSA was provided this information in order to place his name on the TSA "no board" list? If there was a delay, please explain the cause.

Please refer to my response to questions j and k.

n. Did OHA learn that this Mexican national had taken any flights within the United States? If so, who provided OHA this information? Please provide details on the flight information.

In the case of a public health matter, this type of information is obtained as part of the contact tracing investigation conducted by State public health authorities. In this case, the domestic flight history was compiled by the Texas Department of State Health Services (DSHS), working in conjunction with the Project Juntos physician over the course of several days following May 31, 2007, when the person turned over his border crossing card and agreed to cooperate with contact tracing.

After receiving the individual's full and complete name, CBP's search of TECS revealed that the individual made no international flights to a destination to or from the United States. I do not have details on the flight information.

The Texas public health authorities made a determination that no further public health actions were required as a result of their investigations, including domestic flight contact tracing.

o. When were you informed about the Andrew Speaker case?

May 24, 2007.

p. Did you find any similarities between the case of the Mexican national with TB and Mr. Speaker's case?

Both had drug-resistant TB, and management of their cases required coordination between public health and border authorities.

q. Did you or anyone in your office participate in a conference call with other DHS components and the CDC about the Mexican national infected with MDR-TB? If so, please provide the dates and list of participants. Please provide the Committee a copy of your notes from those calls?

I did not. This matter was handled by Dr. William Lang, Associate Chief Medical Officer for Component Services.

r. In those conference calls did you also discuss the case of Andrew Speaker? If so, for what purpose?

(Not applicable)

s. Are you aware of any other case of a person infected with MDR-TB who CDC advised should not be allowed entry to the U.S., but was nevertheless granted entry in the last year?

No.

t. Why did you not disclose information about the Mexican national infected with MDR-TB to the Senate Homeland Security Committee and Governmental Affairs Committee during the June 4, 2006 briefing?

It did not occur to me that the Committee would consider this case, which had already been resolved, germane to the Speaker case. I did mention it to the House Homeland Security Committee staff the day before in a smaller gathering as a footnote to discussions regarding the Andrew Speaker case, as an example of how DHS and HHS/CDC were working to develop formal SOPs to facilitate cooperation and efficiency.

u. Did you or anyone in your office inform other Congressional Committee(s) about the Mexican national infected with MDR-TB before Oct. 17, 2007? If so, when and which Committee(s)?

Please refer to my previous response.

v. Describe the Standard Operating Procedure (SOP) among the CDC, Department of Health and Human Services, and DHS for establishing alerts on travelers who may present a public health threat.

The SOP provides a standardized, reproducible means for passing requests from CDC to DHS entities for assistance with public health issues or requests for information to support contact investigations or quarantine using DHS authorities. The SOPs serve to implement an existing MOU between CDC and CBP. An SOP has been developed for HHS to use to support how they process information within HHS and pass it to the DHS NOC, and another for DHS that supports how the NOC receives the information from the HHS Secretary's Operation Center (SOC). These two SOPs were developed collaboratively and with mutual review by HHS and DHS. A verbal description of the SOPs would be tedious, but I am willing to provide the Committee with a communication protocol diagram (For Official Use Only) as the SOPs are being "finalized."

w. When will the SOP be finalized?

The SOPs have been in use since late spring and are working well. Approved copies signed off by all necessary parties should be available soon. As a practical matter, these SOPs are working documents and will change as the need arises, so are not really "final" in my view.

V. General Management

42. What is your approach to managing staff, and how has it developed in your previous management experiences?

My approach to managing my staff at DHS started with building a base of highly skilled medical, health, and business professionals who are problem solvers and have managed people and programs. I believe in hiring people who can be turned loose to accomplish the objectives given to them and be held accountable for results. This accountability is predicated on receiving support from management, in the form of guidance, clear expectations, feed back and the necessary resources to accomplish the objectives.

This approach has been difficult because of the "start-up" nature of our organization. Our managers have had few personnel to manage, so all of us have been our own action officers dealing with minutia as well as major policy issues. This is typical of any start-up organization, and as we are able to bring aboard more staff, the span of control would narrow to my immediate office and Associate Chief Medical Officers. This likely will not be fully realized under my tenure due to timing and the hiring freeze placed on us by the Continuing Resolution.

Establishing a narrow span of control over daily operational issues allows the Assistant Secretary/Chief Medical Officer to focus more outwardly on the

Department's mission and policy issues and dealing with stakeholders and State and local entities where the successes of preparedness and response are achieved.

At NHTSA, we went through a necessary agency-wide reorganization that was designed to move senior career employees into positions of running the day to day static activities of the organization in three pillars, similar to the organization of OHA. After the reorganization, senior managers had broad latitude in carrying out the plans and priorities of the organization, for which they were held accountable. This structure afforded me the time to focus on carrying out policies of the President and Secretary and focusing outwardly on auto industry stakeholders, safety groups and State and local law enforcement, who ultimately carried out our initiatives.

43. When you were first appointed CMO at DHS in 2005, you managed a staff of three people and a budget of $2 million (FY06). In upcoming months, OHA will increase to approximately 76 staff members with a budget of approximately $118 million. How do you plan to handle the rapid increase in resources and personnel? What will you do to recruit and hire the personnel needed to achieve results?

The answer is reflected in the above questions. Any number of added staff will be a welcome relief to doing every level of task ourselves. Even after this phase of growth, we will not be close to the 700 employees and 300 contractors across all ten Federal regions I managed at NHTSA with its $650 million budget.

In the current fiscal year, OHA requested salary for 49 FTE which will represent an increase of 27 FTE from fiscal year 2007. We identified and prioritized the additional positions and recruitment is ongoing with the current FTE count at 30 (the number of personnel hired or in the hiring process), and with 18 additional vacancies ready for advertisement. While there may be some delay due to the Continuing Resolution, OHA continues to work aggressively to bring individuals on board to fill its programmatic priorities. In addition to FTE, OHA staff is currently composed of 17 Public Health Service Officers (with 20 PHSO vacancies identified), 7 detailees (with 5 detail vacancies identified), 6 interns, and additional programmatic and support contract staff. Most of these hires occurred within the last 12 months. In short, all OHA programs and personnel positions were methodically planned and well positioned for implementation.

Managing this small office is not a heavy lift. The heavy lift is aligning our expected mission requirements with the resource allocation decisions of the Department and the Administration.

What will you do to recruit and hire the personnel needed to achieve results?

Recruitment and hiring will continue along expedited timelines when possible, employing multiple strategies to increase staffing quickly, including:

- Utilizing special appointing authorities such as direct hire, veterans appointing authorities, and student employment programs;
- Recruiting from colleges/universities that have mission-related programs (e.g., programs in national security, homeland security, and biological sciences);
- Participating in job fairs and college recruitment activities including outreach to Hispanic Association of Colleges and Universities (HACU) and Historically Black Colleges and Universities (HBCU) institutions and professional women organizations;
- Using multiple sources to recruit/advertise such as OPM, YRCI, specific websites on the Internet and print media advertising;
- Outreach to employees with disabilities through the DHS Office of Civil Liberties and Civil Rights; and
- Utilizing the Presidential Management Fellowship Program.

VI. Ethics Compliance

You have worked at DHS since September 2005 in various positions - the Chief Medical Officer, Acting Under Secretary for Science and Technology, and as the Acting Assistant Secretary of Health Affairs. In late 2006, the Post-Katrina Act gave the Chief Medical Officer the primary responsibility within DHS for all medical issues, including coordinating DHS's biodefense activities and serving as the primary point of contact with HHS and others regarding medical and public health issues. Additionally, the President's FY 2008 Budget request states that the Office of Health Affairs and the Chief Medical Officer of DHS serve as Department of Homeland Security's principal authority for all medical and public health matters. The Budget request also states that the Office of Health Affairs leads DHS's role in "developing, supporting, measuring, and refining a scientifically rigorous, intelligence-based medical and biodefense program that ensures the public health and medical security of our nation." The Science & Technology Directorate, among other things, processes applications for SAFETY Act protections, some of which are applications from companies seeking protections for pharmaceuticals and other items. When you began working at DHS, you had holdings in pharmaceutical and medical supplies companies, including Johnson & Johnson, Schering Plough, Pfizer, Merck Co., Wyeth, and DuPont, ranging in value from approximately $430,000 – $1 million. In 2006 you sold between $65,000 - $150,000 worth of such pharmaceutical and medical supplies holdings.

We did not sell the securities. We donated approximately $65,000 worth of Johnson & Johnson stock to our university and to our church. There is no choice for "Gave Away" on the electronic version of the SF-278.

44. Name all of your duties and responsibilities as Chief Medical Officer and later as Acting Assistant Secretary of Health Affairs. Since starting to work at DHS as Chief Medical Officer, have your duties changed in any way? If so, describe all relevant changes.

Please refer to my response to question 13a.

45. Name all of your duties and responsibilities as Acting Under Secretary for Science and Technology. Did your duties as Acting Under Secretary for Science and Technology change in any way while you held the position? If so, describe all relevant changes.

My duties as the Acting Under Secretary for Science and Technology are set forth in Title III of the Homeland Security Act of 2002, Public Law 107-296, as amended. The establishment of the Domestic Nuclear Detection Office and the Office of Chief Medical Officer resulted in some realignment of the responsibilities of the Under Secretary of S&T as pertains to nuclear detection and biodefense coordination. Other than those two statutory changes to the scope of the responsibilities of the Under Secretary of S & T, my duties were the same as my predecessor.

46. For each of the following positions, describe the process that was used to ensure you were properly recused from any matters from which you had a potential conflict. Provide the names of all individuals involved in making sure you were properly recused as appropriate.

a. Chief Medical Officer;

b. Acting Under Secretary for Science & Technology;

c. Acting Assistant Secretary for Health Affairs.

I believe I am responsible for ensuring that I have no conflict of interest in matters before me. Within a few months of my transfer into DHS, I made the Designated Agency Ethics Officer (DAEO) aware of specific securities in my family's portfolio.

47. You completed a Public Financial Disclosure Report on March 29, 2005, while working at the Department of Transportation. You started working at DHS as the Department's Chief Medical Officer on September 4, 2005, and completed your first Public Financial Disclosure Report as a DHS employee on May 21, 2006.

a. Describe any measures you took upon your arrival at DHS to avoid any possible financial conflicts issues.

I was informed by the DAEO at the Department of Transportation that my financial disclosure for 2005 would be valid until my next annual filing in 2006, and that any additional ethics issues may be raised by the DAEO at DHS. I understood that I am solely responsible for avoiding any conflicts of interest or appearance of such conflict. I am fully aware of what is in the financial portfolio belonging to members of my family and at no time was this at issue.

b. The DHS Designated Agency Ethics Official (DAEO) told Committee staff that you met with DHS ethics officials in December 2005 because you had concerns about

possible financial conflicts of interest. Was this your first meeting at DHS regarding any potential financial conflicts of interest you may have had? What were your specific concerns at that time? Describe the information you provided in connection with this meeting concerning your financial interests and your official duties and responsibilities to any individuals involved with looking at your potential conflicts.

I do not know the date of the meeting, but agree that I raised the issue with the DAEO shortly after I arrived at DHS. I do not recall the precise content of the meeting, other than the fact that my wife and I owned several pharmaceutical stocks, and I was thus aware of the existence of possible conflicts of interest if I had been asked to be involved in any matters pertaining to those companies. My SF-278 was a matter of record. At no time did I have any dealings with any companies in our portfolio or was in the position to take any action as part of my duties that had any effect on them.

c. The DAEO told Committee staff that based upon the December meeting, he first suggested that you divest certain of your holdings to address potential conflict of interest issues but that you were not interested in divesture as a remedy. The DAEO told Committee staff that he generally prefers divestiture as a remedy, even in circumstances where recusal may suffice. He reported that after further discussion with you, he concluded that recusal would be an adequate remedy and directed you to complete, sign, and return a written recusal agreement. Is this an accurate characterization of your December meeting with the DAEO? Why did you not wish to divest your holdings? What was the basis for determining that recusal was appropriate? From what issues were you to be recused?

I do agree that I was not interested in divestiture. The pharmaceutical stocks in my wife's portfolio were very low-cost stocks that had been in her family for many years. I believed divestiture would have resulted in a large capital gains tax liability that would not have been in my family's best interest to incur. I discussed the matter with the Deputy Secretary at the time, and he concurred with the plan for me to recuse myself if any matters arose, which they did not. At no time was I offered a recusal agreement to sign, although I would have done so gladly. I was not aware, and am still not aware, of a legal requirement to have a written agreement.

d. You became Acting Under Secretary for Science and Technology in February, 2006. What steps did you take upon assuming those additional responsibilities to ensure you did not have any financial conflicts of interest?

I took no additional steps and had no dealings in any matters concerning securities in my family's portfolio. When asked to review and sign approvals for SAFETY Act applications in the April-May, 2006 time frame, I became concerned that I was not cognizant of whether any of those applicants may have been subsidiaries of any companies in which my family owned stock. (As it turned out, none were.) I made my concerns known to the Associate General Counsel in Science & Technology (AGC for S&T) who called a meeting with the DAEO. This meeting occurred on May 8, 2006. The AGC for S&T maintained a list of all of my holdings on his desk which

he used to screen all SAFETY Act applications any other transactions in which my holdings could possibly be implicated. The AGC for S&T was a mandatory reviewer of all SAFETY Act applications (except for General Electric, from which he was also recused) which were forwarded to me for decision.

e. The DAEO told Committee staff that you met with him on May 8, 2006 regarding potential conflicts of interest issues with your new position as Acting Under Secretary of Science & Technology. He told us that he felt your new responsibilities created new ethics issues to consider, potentially more significant than concerns presented by your prior duties. Principally, the DAEO reported that your new responsibilities for considering companies' applications for protections under the SAFETY Act warranted more careful scrutiny. The DAEO has told Committee staff that based upon the May 8, 2006 meeting, he again first recommended that you divest certain of your holdings to address potential conflict of interest issues but that after further discussion he concluded that recusal would be an adequate remedy and directed you to complete, sign, and return a written recusal agreement. Is this an accurate characterization of your May 8, 2006 meeting with the DAEO? Why did you think divesture was not necessary to avoid potential conflicts of interest? What were the specific concerns at that time? What was the basis for determining that recusal was appropriate? From what issues were you to be recused?

That account is consistent with my recollection, except being directed to complete and sign a written recusal agreement. It is my recollection that I inquired whether there was a boilerplate form to sign.

Obviously, the easy answer to possible conflicts of interest is to sell everything that might lead to the appearance of a conflict of interest. I believed that not to be financially feasible, and in fact, recusal was allowed under the rules and all that was necessary. I provided a printout from my Quicken account on-line during that meeting with the exact values listed, to add additional precision to what appeared on the SF-278 in the interest of full transparency. I made it clear that I was to be recused from any matter pertaining to any of those securities. Counsel then suggested a remedy to include screening of meetings and matters that might conflict by informing my key staff of the names of the securities.

f. The DAEO told Committee staff that as a result of this December 2005 and the May 8, 2006 meeting, he asked you on several occasions to prepare and sign a written recusal agreement and return it to him, but that he had no record of ever having received such written recusal agreement. Did you complete the written recusal agreement? If so, please produce such document.

I would dispute the characterization of the DAEO's request stated in this question. My recollection is that I am the one who asked for a standard form for recusal on May 8, 2006. Although a blank form was sent to my staff, I cannot find a copy of a signed form in my records, and I have no recollection of having signed a form.

48. Describe all matters from which you have actually been recused since you have started working at DHS.

There has been no matter of which I am aware from which I have had to recuse myself. The Associate General Counsel in S&T indicated to me that there may have been a SAFETY Act application from General Electric or a subsidiary that by-passed us completely due to the screening process in place.

49. According to your Public Financial Disclosure Report, on April 3, 2006, you sold your Merck & Co. holdings and on September 31, 2006, you sold your Pfizer holdings. Why did you sell these holdings? Did you sell these holdings for any reason related to any actual or potential conflict or because of an appearance of a conflict? At any time before selling the holdings did you learn any material, non-public information related to the holdings as a result of your positions at DHS?

I sold the holdings for the reasons anyone sells holdings – either to raise cash, take gains or stop losses. They were not sold because of conflict or appearance of conflict. I have no knowledge of any non-public information about any stock. I would not have access to that information as part of this position.

50. The Public Financial Disclosure Reports you signed on April 4, 2007, and May 21, 2006, failed to report that you had held or were holding the position of Acting Under Secretary for Science and Technology. Why was this position not included?

It never occurred to me that listing anything other than my permanent title would be necessary.

51. Describe your role in SAFETY ACT issues, including your role in processing applications for SAFETY ACT protections.

Under the Regulations implementing the SAFETY Act (6 C.F.R. 25.3) I was the Secretary of Homeland Security's designee to decide applications for SAFETY Act protections from the sellers of anti-terrorism technologies. In discharging this function, I relied upon the Office of SAFETY Act Implementation and others to conduct the technical evaluations of all applications for SAFETY Act protections and meet with applicants. I made decisions on applications, authorized changes to existing applications and decided relevant SAFETY Act policy questions in consultation with the Office of General Counsel. I was the deciding official and was not *per se* involved in the processing of applications.

52. Name every company involved in SAFETY Act matters on which you worked.

1. Abraxas Corporation
1. Alluviam, LLC
2. ASIS International
3. BAE SYSTEMS Information and Electronic Systems Integration, Inc

4. BioPort Corporation
5. BlastGard International, Inc
6. Cangene Corporation
7. CEIA USA, Ltd
8. Cepheid
9. FP Technologies, Inc
10. Gunnar Office Furnishings
11. Language Analysis Systems, Inc
12. Lockheed Martin
13. Northrop Grumman Security Systems
14. Northrop Grumman Space and Mission Systems
15. Pitney Bowes Inc
16. Rapiscan Security Products USA, Inc
17. Siemens Logistics and Assembly Systems Inc
18. The Raytheon Company
19. Unisys Corp

53. Did you or any of the DHS offices you managed have responsibility for creating incentives for pharmaceutical companies to develop medical or other countermeasures?

No.

54. The Project Bioshield Act of 2004 (P. L. 108-276) requires the Secretaries of HHS and DHS to jointly submit a recommendation for presidential approval to use BioShield funds to acquire countermeasures. The Act also requires the Secretary of HHS, in consultation with the Secretary of DHS, to assess on an ongoing basis the availability and appropriateness of specific countermeasures to address threats identified under the Act. Additionally, the Act requires the Secretary of HHS, in coordination with the Secretary of DHS, to maintain a stockpile of drugs, vaccines and other biological products, medical devices, and other supplies to provide for the emergency health security of children and other vulnerable populations in the event of a bioterrorist attack or other public health emergency.

a. Explain how these processes work, including any role you or any DHS offices you managed played in such recommendations.

These processes can best be explained in the context of the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) which HHS created in July 2006 to take a more integrated, systematic end-to-end approach to the medical countermeasure mission – including research, development, acquisition, storage, maintenance, deployment, and guidance for utilization. The PHEMCE is a coordinated interagency effort overseen by an Enterprise Governance Board comprised of the HHS Assistant Secretary for Preparedness and Response, the Centers for Disease Control and Prevention, the National Institutes of Health, and the Food and Drug Administration. It acts to advise the HHS Secretary, who is the decision authority for use of funds for medical countermeasures. DHS serves as an ex

officio (non-voting) member along with the Department of Defense and the Veterans Administration. As the Chief Medical Officer and Acting Assistant Secretary of Health, I serve as the DHS designee on this Board along with the DHS Under Secretary for Science & Technology. The ultimate goal of the PHEMCE is to prepare the Nation to prevent and respond to the health effects of natural and manmade disasters. Given the diverse nature of the CBRN threat spectrum combined with financial and time constraints, priority setting is an important and necessary element the PHEMCE approach.

DHS' primary role is in the very first stage of this process – identifying and prioritizing programs for the development and acquisition of medical countermeasures – by establishing a relative hierarchy of CBRN threat classes.

DHS' Directorate of Science & Technology (S&T) had the lead in the development of the Bio Threat Risk Assessment (BTRA), which considers the best available intelligence, law-enforcement, scientific, and public-health information to identify and prioritize CBRN threats. DHS uses the BTRA as the basis for issuing Material Threat Determinations (MTDs) which identify agents presenting a material threat sufficient to affect national security. I served as Acting Under Secretary from February-August, 2006, the period during which the majority of the current MTDs were issued. Once the MTDs are identified, DHS then conducts a Population Threat Assessment (PTA) to estimate the size of the population exposed to those agents to gauge the impact on the population and national infrastructure if that particular agent was released for a given plausible, high consequence scenario. Once the MTDs are issued and PTAs are completed for any given threat, the results are provided to HHS to inform subsequent medical and public health consequence assessments. These inputs are used to inform medical countermeasure requirements which are developed by interagency working groups as part of the overall PHEMCE structure.

Upon identification of countermeasures that meet the eligibility requirements to warrant use of the Special Reserve Fund (SRF), the Secretary of DHS and the Secretary of HHS jointly request that OMB release funds to HHS from the Special Reserve Fund (SRF) to acquire the countermeasures. Under section 319F-2(c) (7) (C) of the Public Health Service Act, as amended, HHS is ultimately responsible for managing the countermeasure procurement process including the negotiation of terms and entering into contracts for research, development, acquisition, procurement, storage and distribution of countermeasures. The PHEMCE process is the vehicle by which DHS provides input on the medical countermeasure continuum ranging from research and development to storage, maintenance, and deployment. It is therefore HHS, not DHS, that makes the call on which specific countermeasures to develop, acquire, stockpile and, in the event they are needed, distribute.

b. Since you have been at DHS, what has been your role, or the role of any of the DHS offices you have managed in coordinating with HHS on maintaining this stockpile of drugs, vaccines and other biological products, medical devices, and other supplies?

HHS-CDC's Division of the Strategic National Stockpile (DSNS) is responsible for the acquisition, storage, and maintenance of medical countermeasures and other supplies. With the recognized need to maintain and improve this capability, the DSNS has become an integral part of the PHEMCE described in 54a. Through the PHEMCE, the interagency partners are able to gauge near-, mid-, and long-term priorities for broad types of countermeasures to acquire and deliver into the SNS. HHS then makes the decisions as to which specific countermeasures are acquired. Input from the interagency is neither required nor sought.

55. Have you advised the Secretary of Homeland Security or advised or coordinated with other federal agencies on issues in any way related to the National Strategic Stockpile? If so, describe how. Have you or any of the DHS offices you managed had any role in facilitating the development and production processes that the federal government carries out to pre-purchase countermeasures for biodefense threats for placement into the Strategic National Stockpile?

As the Chief Medical Officer for DHS, using the outputs of the BTRA process, I advise the Secretary of DHS as to which agents constitute a significant threat to the security of the Nation and hence warrant the issuance of a Material Threat Determination. I serve as the DHS lead in coordinating with HHS and other Federal Agencies through the PHEMCE process. Based on these deliberations, I advise the Secretary of DHS as to whether to join the Secretary of HHS in requesting access to the BioShield Special Reserve Fund for a given class of countermeasures.

DHS does not conduct research, development, demonstration, testing, or evaluation activities on human medical countermeasures and does not acquire them for the stockpile. DHS' primary role is identifying and quantifying threats on the front end and in the co-approval of the use of the Special Reserve Fund for countermeasures meeting the requirements. The BTRA also has utility in guiding investments also in earlier stage research and development managed by the HHS/NIH. In this way, DHS does facilitate HHS' research and development investment decisions and thus helps prioritize the use of the Nation's limited resources.

No office at DHS has had a substantive role in any development or production processes for medical countermeasures, other than co-approval of the use of the Special Reserve Fund.

56. Companies in which you have or had holdings, including Pfizer, Schering Plough, Wyeth, and Johnson & Johnson, sell products or have the exclusive rights to products that have been acquired by the Strategic National Stockpile for the treatment of anthrax and other threats. Did you or any of the DHS offices you managed consider any matters relating to the companies in which you have or had holdings, or their competitors, with respect to issues related to the Strategic National Stockpile?

No.

57. On July 30, 2007, Jon R. Krohmer, M.D., Deputy Assistant Secretary and Deputy Chief Medical Officer sent a letter to the Legal Advisor for Ethics/DAEO at DHS to respond to concerns raised regarding potential financial conflicts of interest by the Office of Government Ethics (OGE) regarding your work at DHS.

a. Did you approve the letter before it was sent to the DAEO?

No.

b. Are the contents of the letter accurate and complete?

I have not seen the letter.

c. The first part of the letter lists the responsibilities and duties of Assistant Secretary of Health Affairs/Chief Medical Officer DHS.

i. Do you believe this letter includes all of the responsibilities of the DHS Assistant Secretary of Health Affairs/Chief Medical Officer? If not, please describe duties and responsibilities not included.

I have not seen the letter. Please see my responses to question 13 and the extensive explanations in the previously submitted answers to policy questions.

ii. This letter does not include any reference to or description of the duties of or your activities when you held the position of Acting Under Secretary for Science and Technology. Why not?

I have not seen the letter and cannot speak to your question. Please refer to the question regarding duties as Acting Under Secretary.

d. The letter says that "at the outset" of your DHS service, you recused yourself from participating in matters affecting your financial holdings, especially the four specific companies in which you held securities. When did you recuse yourself from participating in matters affecting your financial holdings, and how was that recusal implemented or documented? What four companies does the letter refer to?

I have not seen the letter and cannot speak to your question.

e. Dr. Krohmer's letter stated that the decision as to the type of medical supplies/countermeasures that should be purchased is the "independent discrete responsibility" of HHS. It also said that DHS policy issues do not extend to the determination of what countermeasures are appropriate and whether those countermeasures exist or could be developed, and that this responsibility lies with HHS. However, in your April 18, 2007 testimony before the House Committee on

Homeland Security, Subcommittee on Emerging Threats, Cybersecurity, and Science and Technology, you stated that HHS created the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) to identify, develop, and acquire medical countermeasures that will improve public health emergency preparedness, and that DHS serves as an ex officio member of PHEMCE. Additionally, the Project BioShield Act of 2004 requires the Secretary of HHS, in coordination with the Secretary of Homeland Security, to maintain a stockpile or stockpiles of drugs, vaccines and other biological products, medical devices, and other supplies to provide for the emergency health security of children and other vulnerable populations in the event of a bioterrorist attack or other public health emergency. Finally, the President's 2008 Budget Request justification states that the Office of Health Affairs, under your direction, serves to coordinate DHS's role in the BioShield Countermeasures acquisition process. This request sought funding for the Office of Health Affairs, BioDefense Countermeasures Office, to "facilitate the development and production processes that the Government undergoes to pre-purchase critical vaccines or medication for biodefense upon subject matter expert approval of the vaccine placement into the Strategic National Stockpile." Do you agree with the text in Dr. Krohmer's letter stating that the decision as to the type of medical supplies/countermeasures that should be purchased is the "independent discrete responsibility of HHS"? If so, how do you square that statement with your testimony, the requirements of the Project Bioshield Act of 2004, and the 2008 Budget Request justification? Please explain.

Although I have not seen the text of the letter, I agree that the choice of countermeasures is made by HHS. DHS is represented in the PHEMCE Governing Board, which provides advice to the Secretary of HHS on the development and acquisition of countermeasures for the stockpile. DHS' *ex officio* seat has been non-voting and advisory. There is no material contribution by DHS as to which countermeasures should be purchased or what brand.

The role of DHS in Project BioShield is to provide Material Threat Determinations and Population Risk Assessments to the Enterprise to guide the PHEMCE in its choice of threats for which to provide countermeasures. OHA represents DHS in the PHEMCE, as does Science & Technology. We facilitate the development and production processes by ensuring that the threats for which BioShield investments are made reflect our best threat analysis. There is no conflict in Dr. Krohmer's letter and my testimony or the budget submission.

f. The letter states that your recusal has been accompanied by a screening agreement. What is a screening arrangement and what does the screening arrangement require? Has the original screening amendment been modified or amended in any way? When did any such screening agreement go into effect? Please provide a copy of such screening arrangement.

In response to your question, to clarify, the operative word is <u>arrangement</u> and not <u>agreement</u>. A written screening arrangement did not exist. The arrangement was

fairly simple – the S&T senior staff and the CMO senior staff were aware of my sensitivity to conflicts of interest or any potential conflicts of interest and screened my schedule accordingly. According to my Deputy, Dr. Jon Krohmer, his letter to DAEO Robert Coyle indicated that, "The recusal has been accompanied by a screening arrangement."

58. The Post-Katrina Act makes the CMO the primary point of contact at DHS for those outside DHS with respect to medical and public health matters. Additionally, the President's 2008 budget request stated that OHA was the "single point of entry for key stakeholders on all medical and public health matters involving DHS" including "private sector stakeholders." Dr. Krohmer's July 30, 2007 letter stated that "it is possible that broad classes of pharmaceutical/agents may be discussed" at meetings in connection to your duties.

a. Please describe in general terms involvement you have had as a DHS official on issues related to pharmaceuticals, vaccines, biological products, medical devices, and other such supplies, either for humans, animals, or plants.

Please refer to my response to question 55.

b. Have you been recused from all meetings with representatives of or meetings that in any way affected the interests of Johnson & Johnson, Wyeth, DuPont, Schering Plough, Pfizer, or Merck Co.?

To my knowledge, there have been no meetings with representatives of these companies, or any meetings that in any way affected any interest of these companies attended by anyone in my office.

c. Have you been involved with any meetings involving or affecting any competitors of the companies listed in question (a)?

No, not to my knowledge.

d. Have you been involved in establishing policies for meetings involving the companies listed in (a) or their competitors or in establishing programs or policies affecting involving the companies listed in (a) or their competitors?

No.

59. On April 18, 2007, you testified about 12 biological threats before the House Committee on Homeland Security, Subcommittee on Emerging Threats, Cybersecurity, and Science and Technology. Do Johnson & Johnson, Wyeth, DuPont, Schering Plough, Pfizer, or Merck Co. manufacture, supply, or market any countermeasures for the 12 biological threats that you discussed in your April 18, 2007 testimony?

Some of these companies very likely manufacture antimicrobials that would be efficacious against some of the organisms among the 12 threats for which DHS has completed Population Risk Assessments, but I have no specific knowledge of that. I do not know which brands of antibiotics they make or if any of those are in the SNS. I do not believe there to be any of the bacterial or Rickettsial organisms among the 12 that are not currently susceptible to generic doxycycline or ciprofloxacin, so I can't think of a reason for the SNS to buy named-brand drugs.

60. On August 6, 2007, you wrote to the DAEO, stating that in order to avoid potential conflicts of interest under 18 USC Section 208, you would divest holdings in Johnson & Johnson, Schering Plough, Wyeth, and DuPont no later than September 29, 2007.

a. What were the reasons that divesture was necessary?

The Office of Government Ethics made the request prior to the President nominating me. I was made aware only at that time of a provision that would allow us to divest of these securities without incurring an untenable capital gains tax liability. That provision made it financially possible for me to accept the nomination.

b. Why didn't these reasons compel you to divest the holdings previously, when you were serving as Chief Medical Officer, Acting Under Secretary for Science & Technology and Acting Assistant Secretary of Health Affairs?

There was no such requirement from the Office of Government Ethics for a Secretarial appointee. Furthermore, as stated above, I reviewed my position with the Deputy Secretary regarding recusal, which he found acceptable.

c. Have those holdings actually been divested? If so, when?

Yes. Divestiture was completed by September 25, 2007.

d. Did anyone ask you, advise you, or suggest that you divest these holdings? If so, describe the relevant communications.

Please refer to my response to question 60a.

61. In hindsight, do you believe you should have divested your holdings in pharmaceutical and medical supplies companies at an earlier time during your career at DHS?

Absolutely not. There was no conflict of interest or any opportunity for such conflict. However, if I had known about the new rule allowing me to swap securities without triggering capital gains tax, I would have taken the opportunity to diversify our portfolio as soon as possible.

62. In the years of 2005, 2006, and 2007, did you receive any compensation from the following and if so what were you paid?

a. Tuckaway Partners, Limited Liability Company (LLC);

No.

b. University of North Carolina - Chapel Hill, School of Medicine;

No.

c. Emily C. Runge Revocable Trust; and;

No.

d. Virginia Deck Runge Irrevocable Insurance Trust.

No.

63. In an August 6, 2007 letter to the DAEO, you stated that you would resign from your position as managing partner for Tuckaway Partners, LLC or that you may elect to dissolve this LLC. You also agreed to resign from your position as Clinical Adjunct Professor at the University of North Carolina at Chapel Hill.

a. What is Tuckaway Partners, LLC? Do you currently hold any other positions in Tuckaway Partners LLC? If so, please name the positions. Do you know why it was necessary to resign from this position or to dissolve the partnership? Have you either resigned from this position or dissolved the partnership?

I set up the LLC, owned only by my wife and me, to invest in commercial ventures, mostly real estate, during the mid-90s. I managed the investments. OGE's opinion was that this appears to constitute "outside employment," even though I believe it not to be. It is merely a vehicle to invest in and manage my family's real estate properties. It should not be considered outside employment to manage one's family assets. As a practical matter, the LLC has sold all of its real estate assets and holdings, other than about $3,000 in cash, as of January 2007. When we dissolve the LLC, we will likely realize some pass-through losses. For tax purposes, I may wait until CY 2008 to dissolve the LLC. My accountant hasn't yet provided me with advice as to which tax year we will dissolve the LLC.

b. Do you know why it was necessary to resign from your position at the University of North Carolina? Have you actually resigned from this position?

This "Adjunct Clinical Professor" title is now essentially an honorary position, since I no longer teach medical students from UNC Chapel Hill, as I did for the years 1984-2001. I do not believe it necessary to resign from my position, but it apparently raises issues of appearance. I have never received a nickel from the University for teaching

their medical students and certainly get no monetary benefit from the title now. I will resign upon confirmation.

64. While working at DHS, have you ever participated in any matters that would have a direct and predictable effect on any of your financial interests?

No. I can assure the Committee that no matter with which I have been involved at DHS or at DOT has had any positive effect, direct or indirect, predictable or unpredictable, on the financial interests of my family or me. I understand the desire to get my response in the record, and I can assure the Committee that no matter with which I have been involved at DHS or DOT has had a direct or predictable impact on any company in which I hold or have held stock.

65. Some of the tax returns you provided to HSGAC are not signed by you and none of them are signed by your wife, which was generally required because you filed joint tax returns with her. Did you file with the IRS and with the appropriate states properly signed tax returns as legally required? Are the returns you produced to the Committee exact copies of the actual returns you filed with the IRS and with the appropriate states? If they are not exact copies, are they different from the actual returns filed in any respect other than the signatures?

We filed all returns with the IRS and all the States as required. The copies of the returns are the exact copies of the returns we filed with the IRS and State tax authorities. Copies of our returns are furnished by our CPA. We do not make copies of our signed returns.

VII. Relations with Congress

66. Do you agree, without reservation, to respond to any reasonable summons to appear and testify before any duly constituted committee of the Congress if you are confirmed?

I will respond to any reasonable summons to appear and testify before any duly constituted committee of the Congress.

67. Do you agree, without reservation, to reply to any reasonable request for information from any duly constituted committee of the Congress if you are confirmed?

I will reply to any reasonable request for information from any duly constituted committee of the Congress, in accordance with laws and procedures.

VIII. Assistance

68. Are these answers your own? Have you consulted with DHS or any interested parties? If so, please indicate which entities.

The answers provided are my own. I received input from my Associate Chief Medical Officers regarding current status of their programs, from my Chief of Staff regarding current hiring status, and my answers were reviewed by the DHS Office of the General Counsel for matters of statutory authority and conflict of interest.

AFFIDAVIT

I, JEFFREY W. RUNGE, being duly sworn, hereby state that I have read and signed the foregoing Statement on Pre-hearing Questions and that the information provided therein is, to the best of my knowledge, current, accurate, and complete.

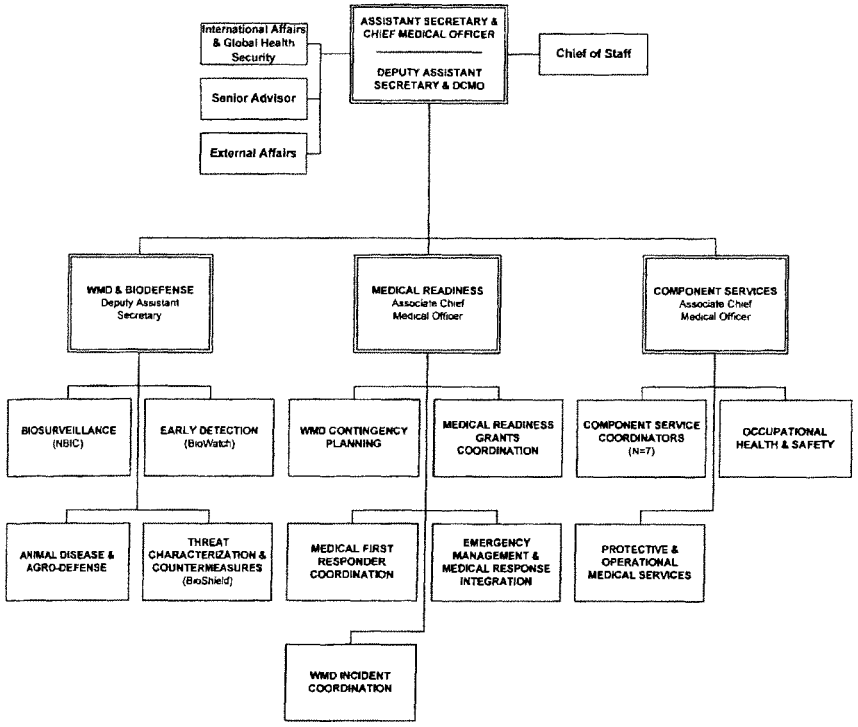
Subscribed and sworn before me this 30th day of November, 2007.

ELMARIA W. JORDAN
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires July 11, 2011

Elmaria W. Jordan
Notary Public

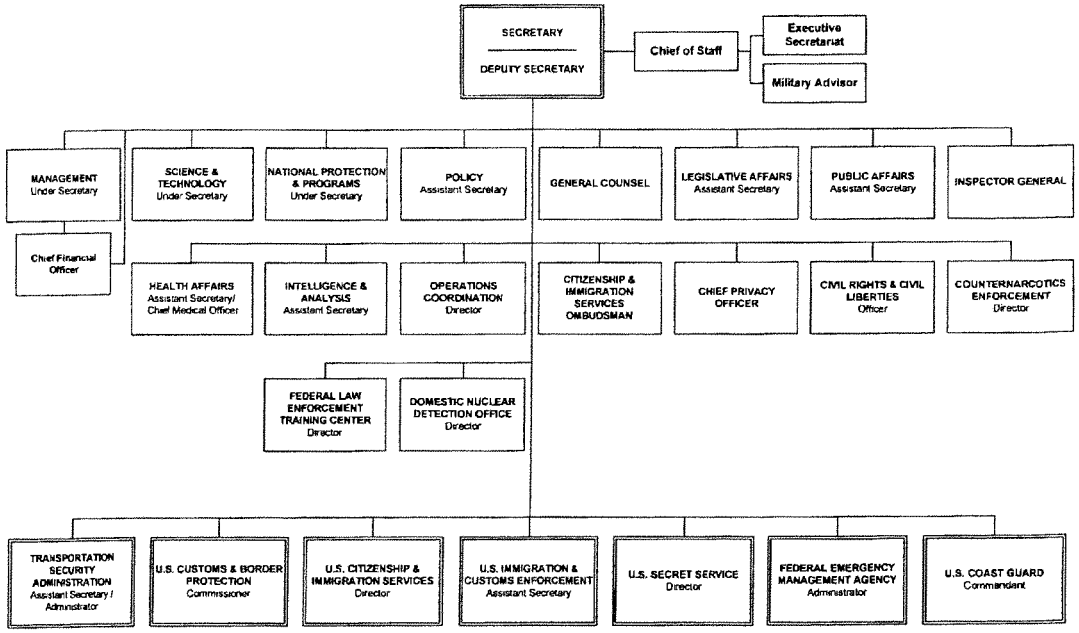
Attachment A

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH AFFAIRS

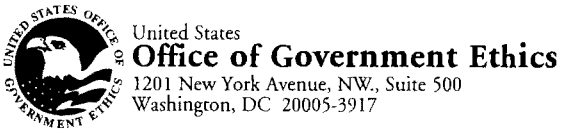


Attachment B

U.S. DEPARTMENT OF HOMELAND SECURITY



Approved 4/1/2007



August 27, 2007

The Honorable Joseph I. Lieberman
Chairman
Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510-6250

Dear Mr. Chairman:

In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Jeffrey W. Runge, who has been nominated by President Bush for the position of Assistant Secretary for Health Affairs and Chief Medical Officer, Department of Homeland Security.

We have reviewed the report and have also obtained advice from the Department of Homeland Security concerning any possible conflict in light of its functions and the nominee's proposed duties. Also enclosed is a letter dated August 6, 2007, from Dr. Runge to the agency's ethics official, outlining the steps Dr. Runge will take to avoid conflicts of interest. Unless a specific date has been agreed to, the nominee must fully comply within three months of his confirmation date with any action he agreed to take in his ethics agreement.

Based thereon, we believe that Dr. Runge is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

Robert I. Cusick
Director

Enclosures

Senator Joseph I. Lieberman
Additional Questions for the Record
Nomination Hearing of Jeffrey W. Runge
December 12, 2007

1. Question 57 of the pre-hearing questionnaire refers to a July 30, 2007 letter written by Dr. Jon Krohmer, Deputy Assistant Secretary and Deputy Chief Medical Officer to the Legal Advisor for Ethics/DAEO at DHS regarding potential financial conflicts of interest related to your work. You have stated that you did not review or approve the letter, and further, did not provide any information for the content of the letter. Without consulting with you or having you review or approve the letter, it is unclear how Dr. Krohmer could accurately report on any potential financial conflicts of interest issues in this letter.

   a. Please explain how Dr. Krohmer generated this letter and whether it is your belief that this letter was an appropriate response to the DAEO's inquiry.

      Dr. Krohmer, my Chief of Staff Steve Lenkart, and Senior Advisor Paul Jones were responding to a request from the Mr. Robert Coyle, Designated Agency Ethics Official (DAEO) to provide information requested by the Office of Government Ethics (OGE). It was their collective opinion that they could collaborate on a comprehensive response to the inquiry without my having to screen the reply. After reviewing the letter, I believe it was an appropriate response to the inquiry. It uses language from our strategic planning process, discussions we had about delegations of authority and our participation in the public health emergency medical countermeasures process with HHS. Much of the language in the first part of the letter I wrote or reviewed previously.

   b. Please review this letter and re-submit answers to question 57 of the pre-hearing questionnaire in light of its contents. Additionally, please identify any information in the letter that is inaccurate or incomplete, if any.

      I have read Dr. Krohmer's letter to Mr. Coyle. See below.

Question 57:

On July 30, 2007, Jon R. Krohmer, M.D., Deputy Assistant Secretary and Deputy Chief Medical Officer sent a letter to the Legal Advisor for Ethics/DAEO at DHS to respond to concerns raised regarding potential financial conflicts of interest by the Office of Government Ethics (OGE) regarding your work at DHS.

   a. Did you approve the letter before it was sent to the DAEO?

      No.

   b. Are the contents of the letter accurate and complete?

The contents of the letter are accurate and complete.

c. **The first part of the letter lists the responsibilities and duties of Assistant Secretary of Health Affairs/Chief Medical Officer DHS.**

   i. **Do you believe this letter includes all of the responsibilities of the DHS Assistant Secretary of Health Affairs/Chief Medical Officer? If not, please describe duties and responsibilities not included.**

      Yes.

   ii. **This letter does not include any reference to or description of the duties of or your activities when you held the position of Acting Under Secretary for Science and Technology. Why not?**

      The issues raised in the Committee's policy questionnaire, as they relate to the S&T Directorate are addressed in my earlier submission. Dr. Krohmer, Steve Lenkart, and Paul Jones discussed a list of questions that were submitted by OGE through the DAEO, and after considerable discussion provided the answers to the questions that were asked. After preparing the letter, it was reviewed and discussed with the DAEO in advance of sending it forward. The letter was a good faith effort to be responsive to the OGE's concerns.

d. **The letter says that "at the outset" of your DHS service, you recused yourself from participating in matters affecting your financial holdings, especially the four specific companies in which you held securities. When did you recuse yourself from participating in matters affecting your financial holdings, and how was that recusal implemented or documented? What four companies does the letter refer to?**

   The advice I received by the DOT DAEO was to continue to recuse myself from any matters involving any companies in which I had a financial interest, as I had been doing for the previous four years at DOT. There was never a document that was presented or executed. I continued to be aware of potential conflicts as I transitioned to DHS. There was no meeting with ethics officials at DHS or any other action before my appointment to be the DHS Chief Medical Officer. I simply continued to take responsibility for any conflict of interest.

   Paul Jones has been my close advisor for the past six years, was my Chief of Staff at NHTSA, and came to DHS with me. He has been aware of my pharmaceutical holdings since our arrival at DHS. While the responsibility for recognizing any potential for conflicts of interest is mine alone, Mr. Jones was alert to any contacts or meetings whereby I might have had a conflict. One of his principal duties was (and is) to screen my schedule and decide what meetings I would take with outside entities. There was no formal dictum or document for this arrangement, as there had not been while I was Administrator of NHTSA. When I filled out my SF-278 in April 2007, I

provided Mr. Jones with a hard copy so that he would be more fully aware of my specific holdings, pharmaceutical or otherwise.

Since none of the companies were involved with our work, no meetings had to be denied or diverted and no action ever came up that would have presented a conflict or the appearance of a conflict.

e. Dr. Krohmer's letter stated that the decision as to the type of medical supplies/countermeasures that should be purchased is the "independent discrete responsibility" of HHS. It also said that DHS policy issues do not extend to the determination of what countermeasures are appropriate and whether those countermeasures exist or could be developed, and that this responsibility lies with HHS. However, in your April 18, 2007 testimony before the House Committee on Homeland Security, Subcommittee on Emerging Threats, Cybersecurity, and Science and Technology, you stated that HHS created the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) to identify, develop, and acquire medical countermeasures that will improve public health emergency preparedness, and that DHS serves as an ex officio member of PHEMCE. Additionally, the Project BioShield Act of 2004 requires the Secretary of HHS, in coordination with the Secretary of Homeland Security, to maintain a stockpile or stockpiles of drugs, vaccines and other biological products, medical devices, and other supplies to provide for the emergency health security of children and other vulnerable populations in the event of a bioterrorist attack or other public health emergency. Finally, the President's 2008 Budget Request justification states that the Office of Health Affairs, under your direction, serves to coordinate DHS's role in the BioShield Countermeasures acquisition process. This request sought funding for the Office of Health Affairs, BioDefense Countermeasures Office, to "facilitate the development and production processes that the Government undergoes to pre-purchase critical vaccines or medication for biodefense upon subject matter expert approval of the vaccine placement into the Strategic National Stockpile." Do you agree with the text in Dr. Krohmer's letter stating that the decision as to the type of medical supplies/countermeasures that should be purchased is the "independent discrete responsibility of HHS"? If so, how do you square that statement with your testimony, the requirements of the Project Bioshield Act of 2004, and the 2008 Budget Request justification? Please explain.

After reading Dr. Krohmer's letter to DAEO my previous answer is correct.

With respect to "squaring" the budget justifications, in October 2007, we finally had the resources to hire an expert in biodefense, Dr. Diane Berry, to participate directly with HHS in the PHEMCE/BARDA processes. This fulfills the Congressional justifications exactly as we intended. She serves as the OHA representative to the new PHEMCE Executive Board, and in that capacity may in fact be in the position to influence "types" of countermeasures. However, the Board is advisory to the PHEMCE Governance Board, on which the DHS CMO sits as an *ex officio* non-voting member, which is, in turn advisory to the HHS Secretary. It is therefore the

"independent" responsibility of the HHS Secretary to decide what countermeasures will be purchased. I do not wish to weigh in on the interpretation of "discrete." It is indeed an enterprise approach involving many players from across the interagency and the private sector.

Here is the answer I provided the Committee:

"...I agree that the choice of countermeasures is made by HHS. DHS is represented in the PHEMCE Governing Board, which provides advice to the Secretary of HHS on the development and acquisition of countermeasures for the stockpile. DHS' *ex officio* seat has been non-voting and advisory. There is no material contribution by DHS as to which countermeasures should be purchased or what brand.

The role of DHS in Project BioShield is to provide Material Threat Determinations and Population Risk Assessments to the Enterprise to guide the PHEMCE in its choice of threats for which to provide countermeasures. OHA represents DHS in the PHEMCE, as does Science & Technology. We facilitate the development and production processes by ensuring that the threats for which BioShield investments are made reflect our best threat analysis. There is no conflict in Dr. Krohmer's letter and my testimony or the budget submission."

f. The letter states that your recusal has been accompanied by a screening agreement. What is a screening arrangement and what does the screening arrangement require? Has the original screening amendment been modified or amended in any way? When did any such screening agreement go into effect? Please provide a copy of such screening arrangement.

"In response to your question, to clarify, the operative word is <u>arrangement</u> and not <u>agreement</u>. A written screening arrangement did not exist. The arrangement was fairly simple – the S&T senior staff and the CMO senior staff were aware of my sensitivity to conflicts of interest or any potential conflicts of interest and screened my schedule accordingly. According to my Deputy, Dr. Jon Krohmer, his letter to DAEO Robert Coyle indicated that, 'The recusal has been accompanied by a screening arrangement.' "

Senator Susan M. Collins
Additional Questions for the Record
Nomination Hearing of Jeffrey W. Runge
December 12, 2007

1. On 26, 2007, the DHS Inspector General (IG) released a report examining the delays in making NBIS operational. In that report, the IG sited "[l]ack of consistent management and a loss of institutional knowledge" as major contributors for the slow development of this system. In large part, this was due to the Department moving NBIS from one component to another over the last two years. Hopefully, its placement within your office will go a long way toward solving this problem. However, the current Director for this program, Dr. Kimothy Smith, is leaving, and there are concerns that this program will suffer once again from the exact pitfalls highlighted in the IG report. What have you and the Office of Health Affairs done to ensure this change in management won't delay full operational capabilities of NBIS?

   I appreciate your acknowledgement of the rocky start of the NBIS program at DHS, which we inherited in September 2006, and the progress we are making. It is important to note that the program was transferred to the office of the Chief Medical Officer (CMO) with no Federal billets attached to it, only contract dollars. At that time, the CMO only had five Federal employees on board, including me; thus, it was a difficult but necessary decision to detail one of them, Dr. Kimothy Smith, my Chief Scientist, to become the interim director of the NBIS program. He was detailed given a one-year assignment to diagnose the challenges and get the program headed in the right direction. He was never intended to be the permanent director, as OPM classified the position as a GS-15, and he would have had to take a demotion to apply.

   Dr. Smith did exactly what I asked him to do, and the program is headed in the right direction. Congress responded to our request for re-programming of funds to implement the Post-Katrina Act reorganization in late June. At that point we were able to acquire the Federal billets designated for the NBIS program. Our Deputy Director, Eric Myers, took the first billet, followed by key staff, some of whom had been working under contract. Shortly thereafter, in August, Congress authorized the program in the 9/11 Commission Act of 2007 as the National Biosurveillance Integration Center (NBIC), which firmly establishes the Center at DHS, a much needed piece of legislation. The NBIS 2.0 platform will be turned on next month, we have six MOUs signed with partner agencies, we have our first detailee (from CDC) on board, and we have a plan to collaborate with the Armed Forces Medical Intelligence Center to provide an interim capability and a method of feeding classified biosurveillance information to the NBIC. With Dr. Smith's scheduled departure after 14 months, a permanent director is being sought. The position has been advertised, and we have several very good candidates from which to choose. We expect to have a director chosen by the end of the month and on board as soon as departmental security procedures will allow.

   In the interim, we should not suffer the problems in management transition characterized by the Inspector General for the following reasons. First, unlike previous transitions, this

one does not transfer the program from one DHS office to another. The NBIC remains an integral part of the Office of Health Affairs within the WMD/Biodefense office under the oversight of the same Associate CMO, Dr. Donald Noah. Dr. Noah is an Active-Duty Air Force officer, a veterinarian and epidemiologist with experience in biodefense programs and intelligence. We fully committed to maintaining the stability of NBIC and continuing to grow the program through the change in directorship. Second, unlike previous transitions, this one does not involve programmatic changes. We will maintain our current course, and the staff will continue to do the same jobs they have been doing. We are continuing the process toward full operational capability by September 2008 and remain committed to providing Secretary Chertoff and other senior leaders with the situational awareness and advice they need to discharge their responsibilities during a biological event.

Senator Mary Landrieu
Additional Questions for the Record
Nomination Hearing of Jeffrey W. Runge
December 12, 2007

1. Despite being one of three primary first responder groups, along with police and firefighters, paramedics have only received 4% of homeland security funds during the last 3 years for vital equipment and training. This has left them short of funds to prepare for a catastrophic disaster or mass casualty event. Do you believe that this grant allocation pattern is cause for concern, and if so, what should be done to change it?

   I agree that Emergency Medical Service (EMS) professionals constitute an essential element of the first responder community. The Department of Homeland Security (DHS) Office of Health Affairs (OHA) has perhaps the strongest, most experienced staff of EMS physicians in the Federal government, and we are committed to ensuring the state of EMS preparedness. For that reason, we created a leadership position entitled Director of Medical First Responder Coordination within our Office of Medical Readiness. We have advertised the position and received applications from several qualified candidates. We are scheduled to fill with the passing of the FY 2008 budget. Unfortunately, we have a $1.4 million shortfall in the proposed Omnibus language compared to the House-passed version and the President's budget request, which was based on our requirements. We will need to analyze competing requirements to know whether this position can actually be filled.

   The office will serve as the focal point and key contact for the EMS community within DHS. One of its first goals will be to analyze and improve the DHS grants and training programs related to EMS and to coordinate with the FEMA Grants office and the U.S. Fire Administration's grants and programs in EMS. We receive good, frank direct input from stakeholders, many of whom are our friends and former colleagues. This has given the OHA unique insight into the requirements and the failings of our support for EMS.

   The Director of the office will have strong support from the office of the Assistant Secretary and other elements in OHA that are already focused on EMS and on grants coordination between DHS and Health and Human Services (HHS). I was Administrator of the National Highway Traffic Safety Administration from 2001-2005, the agency that led EMS advocacy at the Federal level for 35 years, since the inception of EMS. I worked hard to include language in the Safe, Accountable, Flexible, Efficient Transportation Equity Act (SAFETEA-LU) to authorize the Federal Interagency Committee on EMS (FICEMS) with statutory membership from the interagency. One of the goals of FICEMS is to coordinate among granting agencies for the benefit of EMS as a whole. In addition, our Deputy Assistant Secretary, Dr. Jon Krohmer, is an internationally known EMS physician, and his work has helped set the standards for EMS across the country. One of the reasons I chose Dr. Krohmer, now a member of the career SES, is the credibility he has with the EMS community and the passion for EMS he brings to the job. The grant allocation pattern you referenced is certainly something that

the EMS community recognizes as well, and we intend to address it as our office gains increased staffing and capabilities.

2. The Department's Metropolitan Medical Response System provides grants to EMS organizations and public health officials to prepare for a mass casualty event. The President has zeroed out funding for this grant program in recent budget proposals however, compelling Congress to restore the funding.

   a. Do you believe that the Metropolitan Medical Response System is an effective program?

      Yes, I believe that Metropolitan Medical Response System (MMRS) can be very effective, and has shown itself to be so in many jurisdictions receiving funding. We have worked closely with several MMRS jurisdictions regarding priorities and the uses of their funds, as well has having met with most of the MMRS directors in the past several months. It stands alone as an entity funded by the Federal government to ensure that a cross-disciplinary group of community planners, emergency managers and responders of all types can come together to integrate preparedness efforts.

   b. Would you oppose attempts to abolish the program by eliminating funding for it?

      We will work through the budget process in the coming years to express our support for MMRS in hope that it will receive adequate funding in the President's budget. The FY 2007 DHS Appropriations language directs the Chief Medical Officer to serve as the Department's primary point of contact for State, local, and tribal governments, the medical community, and others within and outside the Department, with respect to medical and public health matters. However, Congress has not given authority over the MMRS program to OHA, but has placed it under the jurisdiction of FEMA. OHA will continue working with FEMA on behalf of the MMRS jurisdictions to ensure that medical response is properly addressed.

Senator Carl Levin
Additional Questions for the Record
Nomination Hearing of Jeffrey W. Runge
December 12, 2007

1. Do you have an opinion as to whether the federal guidance should be revised to permit the availability of the anthrax vaccine for first responders?

2. If you believe that first responders should be allowed to use the anthrax vaccine, do you have an opinion as to whether a vaccine category should be added to the Standardized Equipment List (SEL) and Authorized Equipment List (AEL)?

3. Do you have an opinion on whether states should have the option to purchase these grants using Homeland Security dollars in order to vaccinate emergency first responders?

Given the fact that there exists treatment for anthrax infection, the question of whether to institute a new vaccine regime involves a number of complex factors including the adverse reaction profile of the current vaccine, the need for an effective system of vaccine surveillance, and the need for remedies to those who suffer adverse reactions to the vaccine. The federal government learned a great deal from the smallpox vaccination initiative. As a result, we feel the need to have answers to all of the potential pitfalls related to an anthrax vaccination program before moving forward, especially given the existence of a treatment. OHA and S&T have made this a priority; they will do so in a scientifically-rigorous manner. After extensive discussion with them and the Interagency Board medical subcommittee, our colleagues at HHS have asked the Advisory Committee on Immunization Practice (ACIP) to revisit their previous position regarding the lack of need for pre-exposure prophylaxis of first responders.

You make mention in your question regarding the availability of vaccine to the first responder population. I feel it important to note that the AVA vaccine is FDA approved and available. There are no current impediments to a response system purchasing and instituting a vaccination program prior to DHS endorsement. As to the question of including AVA on the AEL and SEL, we are working with S&T and the IAB regarding of the use of AVA vaccine as a DHS sponsored/funded therapy. We appreciate the need for expedition in these matters but it is equally important that we determine, with scientific rigor, that the addition of items to this list is in the best interests of our nation's response community.

Senator Jon Tester
Additional Questions for the Record
Nomination Hearing of Jeffrey W. Runge
December 12, 2007

1. During the hearing, the need to better utilize the private sector in partnership with DHS on major disaster response was briefly discussed. What recommendations do you have for how best to encourage this kind of increased participation by the private sector in both preparation and response to major disasters, especially bioterrorism and agriculture?

   Of our critical infrastructures and key resources, 85% are owned by the private sector. The vast majority of our healthcare facilities and half of our EMS providers are privately owned. Any major biological or agricultural event could have crippling effects on the private sector, including critical infrastructure. We have noted during our pandemic influenza planning that many businesses are willing to plan and prepare for catastrophic events, largely due to the need for business continuity planning. In fact, they have been a source of innovative ideas. Our problem is that there are precious few incentives to encourage businesses to invest in preparedness for low-probability events. We have already engaged certain sectors as well as the academic community in a discussion of whether the creation and application of preparedness standards may be an incentive that rewards an enhanced state of preparedness through liability protection, reduced insurance rates, and so forth. These conversations are early but proceeding in earnest.

   The equities and capabilities of the private sector are best integrated into our Nation's overall preparedness by including them in the contingency planning process. The National Response Framework lays out a cascade of planning levels (e.g., strategic, operational, and tactical). DHS intends to engage the private sector actively at each level of planning. OHA's planning responsibilities for biological incidents are largely strategic. In our planning for these threats, I will work with our counterparts at HHS and USDA and with private entities such as pharmaceutical producers, medical provider organizations, and animal agriculture corporations. All have a stake and roles to play in our Nation's planning and preparation for its biodefense.

Senator Daniel K. Akaka
Additional Questions for the Record
Nomination Hearing of Jeffrey W. Runge
December 12, 2007

1. During your confirmation hearing, in response to an inquiry regarding collaboration with the International Species Information System-Zoological Information Management System, you stated that systems such as the ZIMS and Global ARGUS were expensive and that OHS could not afford funding to help these programs complete their work.

   While setting priorities in an office budget is extremely important, addressing future biological threats, including emerging zoonotic diseases, should remain a high priority. Investments into data gathering systems such as ZIMS, a real-time, international situational awareness system for tracking zoonoses at zoological institutions, should be part of the NBIC arsenal. Until very recently, ISIS-ZIMS was included as a priority project in NBIS' FY08 budget and was at the contract stage – a partnership process that was over one year in the making.

   As you may know, ISIS testified before the Subcommittee on Oversight of Government Management in October. Private sector data should be cultivated to enhance the coverage of critical surveillance gaps as mandated by the Implementing Recommendations of the 9/11 Commission Act of 2007 (P.L. 110-53). I strongly encourage you to reverse this decision and provide funding for this project whether through NBIS or other OHA funds.

   With this in mind, what will you do to rectify this situation?

   In short, surveillance data sources--from all sectors, public and private--are and will remain a high priority for NBIC. However, this situation deserves a more comprehensive view. NBIC was created to take advantage of and integrate existing data in order to provide the Secretary and other decision makers with a biological common operating picture. This is the mission for which we were funded and remain poised to accomplish.

   In the specific example of ISIS-ZIMS, there are no existing data in the data sets. Although they have very admirable plans to build a globally networked system to integrate information from many partner institutions, they are at least two years from doing so. Until that time, there is no added situational awareness to be gained by the system. We are neither responsible for nor funded to build out additional surveillance systems beyond what currently exists. When ISIS-ZIMS and other well-conceived data sources become operational and have data available, we will work with OMB and Congress to allocate the necessary funds to incorporate them into our system. If the Congress believes that it is within the purview of the NBIC to build out systems for all the areas from which we would like to receive data, we are ready to take that direction, but the funds to do so do not currently exist in the NBIC budget.

2. Scientists report that more than two-thirds of newly emergent infectious diseases over the past several decades have had their origin in animals.

   a. How do you integrate animal diseases into OHA's work?

   You are correct in that the majority of disease threats are those shared between humans and animals. We are working very diligently with our partners at USDA to identify and incorporate existing surveillance data from the nation's animal populations. One limiting factor in this effort is the relative paucity of systematic surveillance across those animal populations. Therefore, the focus of our efforts is to 1.) Identify opportunities to expand the national surveillance coverage and 2.) Collaborate with those agencies within USDA who have the primary responsibility to initiate and maintain those surveillance networks.

   To address the multi-species aspect of the biological threat, I intentionally crafted my staff at OHA with both human and animal disease experts. As you may know, both the American Medical Association and the American Veterinary Medical Association have a joint 'One Medicine' theme this year. I'm proud to be a very active practitioner of this 'One Medicine' concept. As you are aware, veterinarians occupy key positions in the OHA, including the Acting Deputy Assistant Secretary for WMD and Biodefense, the Director of OHA's Food, Agriculture, and Veterinary Defense Division, and the interim Director of NBIC, who is now our representative at the State Department. Additionally, we are in the final stages of bringing aboard at least one experienced analyst from USDA to work side-by-side with the other analysts and epidemiologists at NBIC.

   b. Please discuss activities you have put in place that would address the threat of diseases from wildlife reservoirs to humans.

   We recognize that there are gaps in our national disease surveillance of wildlife. The one major exception to this is pandemic influenza--we are actively engaged with our partners at USDA, HHS, the Department of the Interior, and the Department of Defense in surveillance of avian populations for current and emerging influenza virus strains.

3. How would you set priorities for disease surveillance, or for those diseases with pandemic potential that may still be circulating within wildlife populations?

   Receiving early evidence of the spread of H5N1 disease is a very high priority, as defined in the National Implementation Plan for Pandemic Influenza. We also recognize the disease potential in humans presented by other zoonotic diseases (e.g., Rift Valley fever, Hantavirus, plague, and the viral encephalitides) and intend to be vigilant toward those diseases as well. Other high priority disease surveillance areas are those that can have devastating effects on the U.S. economy and the agricultural community, such as foot and mouth disease, classical swine fever, Brucellosis, and tuberculosis.

4. **What are some of the mechanisms you see for informing Congress and the public about the ongoing status and location of risk of disease movements?**

The primary method of communicating epidemiological situational awareness will be via NBIC's biological common operating picture (BCOP). The BCOP consists of a pictorial depiction of disease events worldwide, an assessment of the homeland/national security impacts of those events, and a trend forecast regarding those events. This unique product will keep the DHS Secretary and other policy makers aware of the biological component of the overall common operating picture. As always, we will remain available to apprise Members of Congress, and will do our best to keep Congress informed of any emerging situation that we think would be necessary for the members to know in real-time.

5. **Do you see value in NBIS integrating information from veterinary schools, schools of public health, and research institutions that are advancing conservation medicine, the applied science for protecting wildlife, human, and ecosystem health?**

I see great value in incorporating surveillance data into NBIC from various sources. Where those data sources are available and NBIC is funded to do so, we will incorporate them.

6. **What mechanisms do you envision creating to foster better communication among federal agencies, industry, academia and research institutions concerning infectious disease threats? Do you see a role for institutions that have expertise in infectious disease risk analysis assisting in this effort?**

It is vital that decision makers across the Federal government have the same data upon which to base their decisions. Our commitment to the BCOP is an important ingredient in their awareness. In addition, having detailees from the NBIC partner agencies present every day in the NBIC will serve to keep their chains of command aware of any information they need to know about animal or human health, food, water, and the environment.

We have had productive discussions with members of the private sector and with State governments about their participation in the NBIC as well, either directly or via their normal Federal linkages. We are already tied in with the DHS Centers of Excellence in terms of information sharing and reach-back, and we see an expanded role for them in the future in terms of analysis and more intensive study of our observations. We are also tied in with private sector owners of critical infrastructure/key resources via the National Infrastructure Coordination Center (NICC), a part of the National Operations Center (NOC). As this relationship matures, it will enable us to make our private sector partners aware of things they need to know about disease threats. The NBIS 2.0 system is configured to be able to protect and manage data that are competition sensitive, law enforcement sensitive, to protect privacy of individuals and other levels of classification the NBIC partners require.

7. **Your office oversees contingency planning, readiness of medical first responders, WMD incident management support, and medical preparedness grant coordination. The Pandemic and All-Hazards Preparedness Act (P.L. 109-417), signed into law in December of last year, established the Department of Health and Human Services (HHS) as the lead federal agency in responding to the health components of public emergencies. How does your office integrate its responsibilities with those of HHS?**

The PAHPA Act was written to bring together the many assets of HHS for the purpose of enhancing public health preparedness, but not to subsume the responsibilities of the Secretary of Homeland Security as the overall incident manager, pursuant to HSPD-5, *Management of Domestic Incidents*. HHS has sole authority over public health and medical treatment of the population in a catastrophic event. HHS also has the responsibility for health care facilities and medical countermeasures, including development, acquisition, stockpiling, and distribution. All those elements are critical to, but not all-inclusive of, a comprehensive strategy for end-to-end planning and management of a catastrophic event. The OHA works very closely with the Assistant Secretary for Preparedness and Response (ASPR) at HHS and supports the ASPR in discharging its responsibilities. OHA is the Secretary's agent for assuring that the efforts of HHS are coordinated with other emergency support functions and are meeting his requirements under HSPD-5.

OHA has been given the responsibility by Secretary Chertoff to develop comprehensive plans and playbooks for the biological planning scenarios, in coordination with the Incident Management Planning Team and FEMA. These scenarios include pandemic influenza, foot and mouth disease, anthrax, plague, and food-borne illness. The Federal strategic plan for pandemic has been delivered to the White House by the IMPT/OHA team. Our next priority is to create Federal strategic plans for anthrax and for foot and mouth disease. HHS currently has playbooks for an anthrax attack written that provide for the operations of HHS assets. Likewise, USDA has playbooks for agricultural entities dealing with foot and mouth disease. Even with the existence of these agency-specific plans, there is lacking a strategic plan that includes our end-to-end strategy, incorporating strategy for intelligence, bio-security, bio-forensics, early warning, bio-surveillance, countermeasure development and delivery, and environmental, psychological and physical recovery. The end-to-end plan will incorporate the operational planning that has been done by the Departments and other entities to ensure its coordination across the Federal government, States, local governments and the private sector.

The role of interagency partners is this process requires a significant investment in the IMPT strategic planning process with time and talent. Every relevant agency should be required to provide planning expertise to the effort, a request that Secretary Chertoff made to the interagency in 2006. HHS provided a fulltime detailee to the IMPT, and this individual was vital to the writing of the plans for pandemic influenza. We expect the same level of investment from other departments as we prepare plans for the other biological scenarios. In this way we assure complete integration, situational awareness, and intellectual participation in the planning process by the Federal interagency.

In addition to the Federal interagency, other partners are also essential in some circumstances. For example, OHA included the Associations of State and Territorial Health Officials and the National Association of City and County Health Officials in the Border Management Plan for pandemic. We believe that it is critical to include all the relevant stakeholders including the private sector and non-governmental organizations in the planning process. We are awaiting a passage of the FY 2008 budget in order to provide manpower and subject matter expertise to the IMPT for the next phase of planning.

8. **Please describe what you see as the role of your office during emergencies? How does that differ with the role of HHS? How can you ensure the Office of Health Affairs (OHA) is not duplicating efforts at other agencies, but remaining a relevant and effective Office?**

The Office of Health Affairs was authorized in the Post-Katrina Act (P.L.109-295) to be the principal advisor for the Secretary and the FEMA Administrator on medical and public issues. This role is particularly important during an incident involving any agent across the chemical, biological, radio-nuclear spectrum or any other event that results in a large number of causalities. In discharging this duty, the Office of Health Affairs has a robust 24/7 presence in the National Operations Center and, during an event, in the National Resource Coordination Center. HHS' role during an incident is to manage Emergency Support Function 8 (ESF-8), Public Health and Medical Services. HHS is the lead agency for ESF-8, and is thus solely responsible for health care delivery during an event. OHA has no role in such health care delivery, but rather serves as the Secretary's agent to ensure that these responsibilities are being accomplished and that HHS is receiving the support that it needs from the department to discharge its duties. Other emergency support functions will naturally need to interact with ESF-8, including mass housing, transportation, communications, law enforcement, and in some instances agriculture. It is OHA's job to make sure that the coordination that HHS requires in order to discharge its duties is being accomplished. We understand that if the management of incidents does not go well, the buck stops at the Secretary of Homeland Security, not the lead agencies for the emergency support functions. It is therefore our commitment that we support the DHS Secretary in any event requiring health and medical support in order to meet his responsibilities. OHA thus serves as the Secretary's agent on all medical and public health matters as relates to other Federal agencies, state and local governments, and the private sector, in accordance with PL 109-295.

9. **What are you doing to ensure that DHS is integrating its emergency planning with HHS?**

Please see the response to question #7.

10. **The President's FY 2008 Budget Request recommended cutting funding for upgrading state and local capacity to respond to bioterrorism and other public health emergencies by $84 million. The President also requested that the Bioterrorism Hospital Preparedness Program, designed to increase hospital surge capacity, be cut by $60 million.**

Since part of your responsibility is to coordinate with HHS on public health preparedness issues, and you are directly responsible for first responder readiness and coordination of medical preparedness grants, you have some understanding of these budget proposals, even if they are not in your direct line of responsibility.

Do you believe the federal government is providing specific guidance and performance measures with respect to creating surge capacity?

As a Presidential appointee, I support the President's FY08 budget request. Requirements for grant funding should ideally be the result of a deliberative planning process, including the defining of desired capabilities, the actions and tasks to be performed to achieve those capabilities, and requirements to fulfill the tasks and actions. These requirements should drive the budget process, and grants to States and local governments should be used to fund those requirements. Those entities should then be held accountable for using those funds to train, equip, and exercise the plan and providing feedback to improve the plan. When we are where we need to be in our deliberative planning for the biological scenarios, a very rational set of funding requirements should emerge. Requirements for a certain level of surge capacity will be considered in the planning process.

In the meantime, capable decision makers have determined that certain improvements to the public health system and health care entities were needed to enhance our level of preparedness. The guidance for these grants has been coordinated through an inter-agency process upon which we have recently been participating. As the Committees is aware, the OHA has a very capable individual, Dr. Laurence Raine, who is coordinating with the interagency to drive requirements for the grants as we understand them today. We continue to be diligent in our attempts to coordinating with the FEMA Grants office, offering expertise in medical and health issues, per our duty under PL 109-295.

11. What is your office doing in the area of surge capacity regards to first responder readiness?

The OHA is not engaged in defining requirements for surge capacity for first responder readiness. The OHA is a member of the Federal Inter-Agency Committee on EMS, which has a working group that is beginning to address this issue for medical first responders. As I stated in the answers to the questions above, requirements should be driven by a deliberative planning process that involves the interagency, State, local and tribal governments, and the private sector. Obviously many catastrophic events will outstrip any surge capacity planning, so it is therefore necessary to define the capabilities of that we believe are reasonable for first responders, first receivers and others.

12. Do you have any estimates as to the cost of creating a minimum level of surge capacity when it comes to first responders and EMTs, which seem to be in your office's jurisdiction?

Please see the answer to question 11. We do not have any estimates as to the cost to create a minimum level of surge capacity for medical first responders.

13. **In the case of a pandemic or other major incident of bioterrorism hospitals would be quickly overrun by patients. What is your office doing, either on its own or in coordination with HHS, to develop non-hospital based medical surge capacity?**

The issues of medical surge capacity are in the sole jurisdiction of the Department of Health and Human Services. Our office is coordinating with the Assistant Secretary for Preparedness and Response on many levels, including the coordination of grant guidance for Health Systems Preparedness. We also collaborate with HHS on the creation of policies that deal with the issue of constrained resources during catastrophic events, specifically pandemic.

14. **How are you coordinating your grants, guidance, and programs for first responder readiness and the work of HHS and the Department of Veterans Affairs in this area?**

Dr. Raine is also responsible for coordinating grant guidance with HHS and the Federal interagency on matters of health preparedness. We have not been as successful as we would like to be in driving requirements for health preparedness based on deliberative contingency planning, due to constrained resources. As our office increases staff and capacity with the passage of the FY 2008 budget, we are committed to improving our success in the area of coordination with FEMA and the interagency on first responder readiness.

15. **What level of funding is needed to establish the Biosurveillance Division (National Biosurveillance Integration Center) fully online?**

The President's budget contains $8 million for the NBIC. With those funds, we will be able to operate and maintain the NBIC 2.0 system, to provide workspace, facilities, and IT support for the program, to fund seven Federal positions and the necessary contract support to become operational. At this level of funding, however, we are dependent upon the Federal NBIC partner agencies to provide detailees for the NBIC at their expense. This level of funding does not provide for development or support of additional data sets beyond the NBIC Federal partners. We will be making our case to the department to support additional requirements the NBIC in the out-years as part of the 5-year Resource Allocation Process.

16. **How does this program relate to the call in the Homeland Security Presidential Directive-21 (HSPD-21) for the Secretary of HHS to build an operational national epidemiologic surveillance system?**

HSPD-21, *Public Health and Medical Preparedness*, directs the Secretary of HHS to build a national biosurveillance system for Human Health. The Presidential Directive also directs HHS to utilize existing systems for integration and coordination, which refers directly to the NBIC. This directive under HSPD-21 is intended to improve human

disease surveillance, which will provide better inputs into the NBIC, which has a broader responsibility for the integration of surveillance in animal health, food water and the environment.

17. **How are agrodefense efforts coordinated between the Biodefense Office in OHA and USDA and other agencies that monitor zoonotic diseases?**

The Office of Food Agriculture and Veterinary Defense within our Office of WMD/Bio-Defense coordinates closely with the USDA and other Federal agencies, such as FDA, that have the necessary resources and authorities to improve the defense of the nation's food supply. One of the lessons we learned after taking over the NBIS program was that there are very few mature data systems across the government for Veterinary and Agro-Defense. We are looking forward to having detailees from the USDA and the FDA within the NBIC who will have access to the data that do exist on animal epidemiology and food safety. The OHA is the Department's lead office for Food and Agro-Defense, and we recognize that the capacity to deliver our responsibilities under HSPD-9 depend greatly on the robustness of our partner agencies. Coordination is therefore essential for our success.

American College of Emergency Physicians
ADVANCING EMERGENCY CARE

December 13, 2007

The Honorable Joe Lieberman
Chairman
Senate Committee on Homeland Security
and Governmental Affairs
SD-340
Washington, DC 20510

Dear Chairman Lieberman:

On behalf of the American College of Emergency Physicians (ACEP), I would like to express our strong support for the nomination of Jeffrey W. Runge, M.D., as Assistant Secretary for Health Affairs and Chief Medical Officer at the U.S. Department of Homeland Security (DHS). ACEP is a national medical specialty society with more than 26,000 members, dedicated to improving the quality of emergency care through continuing medical education, research, and public education.

Dr. Runge is an emergency physician who has spent his life in the field of trauma care and injury prevention. After attending medical school at the Medical University of South Carolina and completing his residency in emergency medicine in Charlotte, North Carolina, Dr. Runge practiced and taught emergency medicine at Carolinas Medical Center in Charlotte for 17 years.

Dr. Runge began his public service when he became Administrator of the National Highway Traffic Safety Administration (NHTSA) in 2001. His service to this nation continued when he became the U.S. Department of Homeland Security's first Chief Medical Officer (CMO). As CMO, Dr. Runge's dedication and experience ensure that the Secretary of DHS and the Administrator of FEMA receive the best counsel on public health and medical issues in preparation for, during, and while recovering from a disaster or harmful event.

ACEP is proud of Dr. Runge's service to his patients, his colleagues in emergency medicine and this nation. We fully support his nomination and urge the committee to approve his appointment.

Yours truly,

Linda L. Lawrence, MD, FACEP
President

CC: The Honorable Susan Collins

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The Nation Looks At New Orleans

A NATIONWIDE ONLINE SURVEY
BY THE UNO SURVEY RESEARCH CENTER

Dr. Robert T. Sims, Director
rsims@uno.edu

Alicia N. Jencik, M.A. – Research Associate
Hung-Chung (Joe) Wang, M.A. – Research Associate

December 10, 2007

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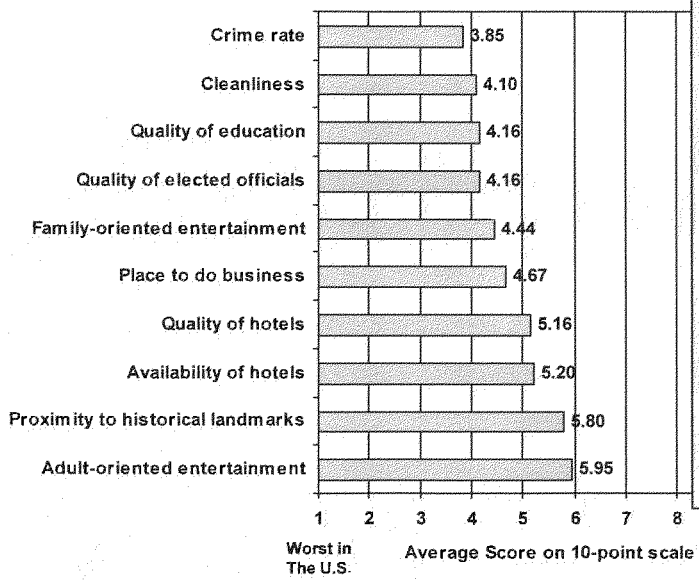
Methodology

- Online survey of 775 U.S. residents NOT including Louisiana
- Margin of error = ± 3.6%
- Sample is representative of U.S. voting age population in terms of median income, gender and ethnicity
- Interviewing took place between November 29 and December 4, 2007.

How the Nation Views New Orleans



- At this time, the nation's opinion of New Orleans clearly tends toward the negative
- The city's reputation as a high crime area has clearly permeated the nation's consciousness
  - New Orleans is also thought of as relatively dirty, offering poor quality education, and guided by poor quality elected officials.
- The city's reputation as a tourist destination is a little better than its general reputation for quality of life.
  - However, even on factors such as the quality and availability of hotels, average ratings fall barely over the scale midpoint.

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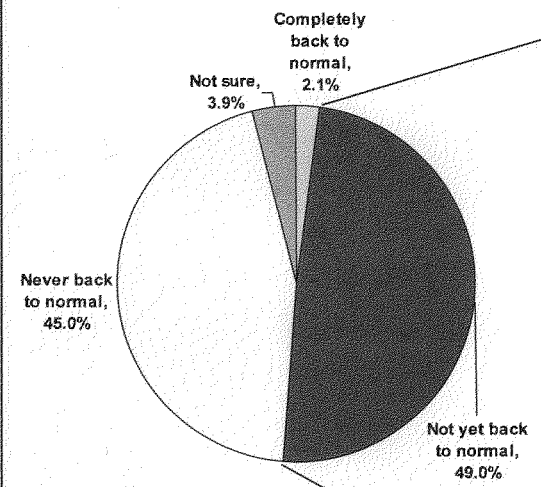
Question: Please rate the City of New Orleans, post-Katrina, on the following criteria

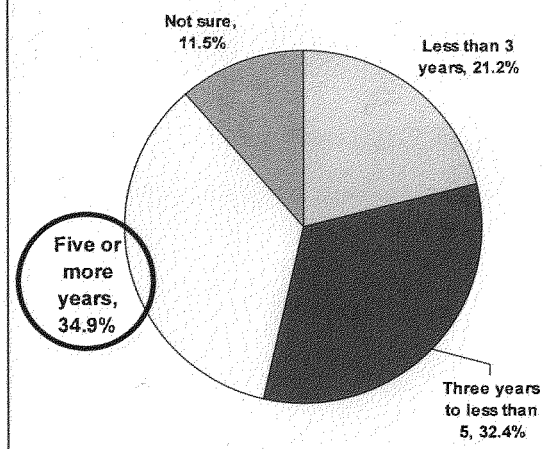
Perception of the Recovery

Question: Would you say things in New Orleans are now completely back to normal, are not yet back to normal, but will eventually be, or will never be back to normal?



•Nearly all respondents (94%) indicate a belief that New Orleans is not yet (49%) or will never be (45%) back to normal.

Question: How long do you think it will still take before things get back to normal for New Orleans?



n = 410

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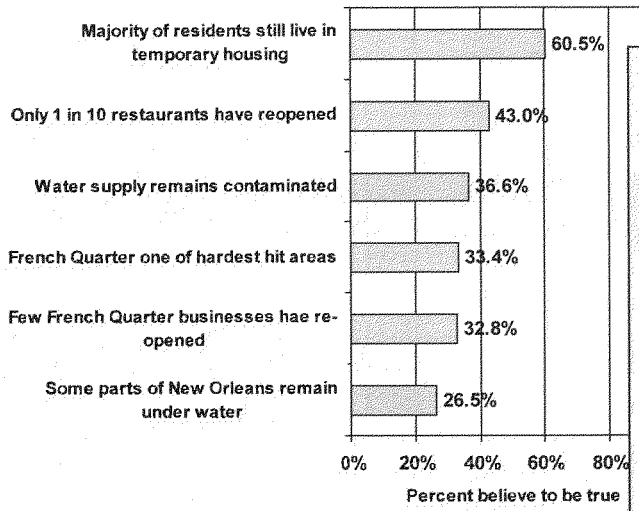
Perception of the Recovery



- An alarmingly high percentage of respondents maintain mistaken beliefs concerning post-Katrina New Orleans.
- For example, over 60% believe that the majorit of New Orleans residents still live in temporary housing, while at least one-third believe that .
  - Only 1 in 10 area restaurants have reopened
  - The French Quarter was one of the hardest hit areas
  - Most French Quarter businesses remain closed
  - New Orleans residents must still drink bottled water because the water supply remains contaminated
  - Parts of New Orleans remain under water

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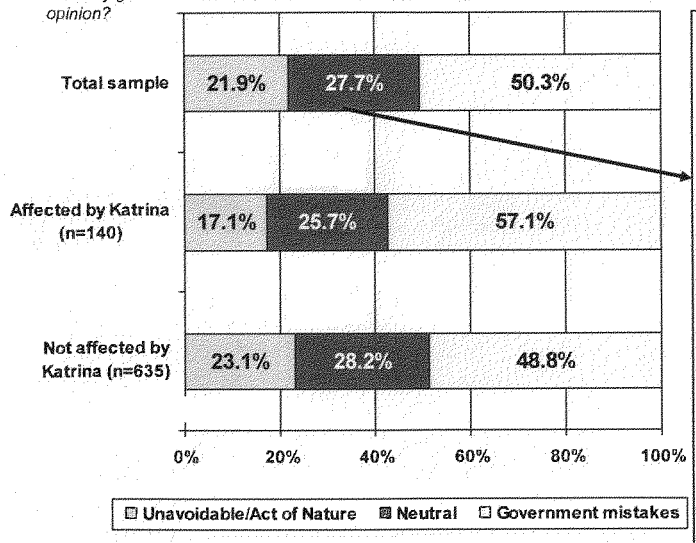
Question: Which of the following items do you believe to be true?

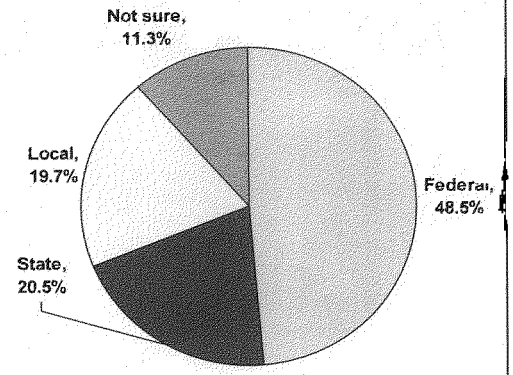
Perception of the Recovery

Question: Some people say that the devastating problems that New Orleans has faced since Hurricane Katrina are completely the result of an act of nature and could not have been avoided. Others say that, though some damage was inevitable, most of the problems that New Orleans has faced since Katrina are the result of mistakes made by government both before and after the storm. Which comes closer to your opinion?



•About half (48.5%) of respondents who felt that New Orleans' Katrina problems were caused by government say the Federal government is most to blame.

Question: Which level of government do you believe is or was most to blame for any problems that have been faced by New Orleans as a result of Hurricane Katrina?



n = 390

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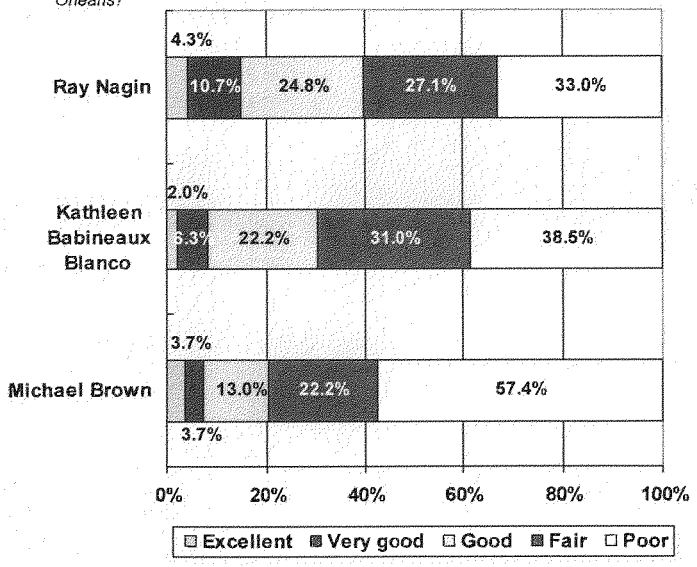
Leader Performance Ratings

Question: Based on everything that you have read, heard or experienced since the time Hurricane Katrina hit, how would you rate the job that [NAME] has done with regard to the recovery of New Orleans?



- Though neither local, state nor Federal leaders rate high in terms of their handling of recovery in New Orleans, New Orleans Mayor Ray Nagin and Governor Kathleen Babineaux Blanco both rate substantially higher than Michael Brown who served as FEMA director at the time of Katrina and during its immediate aftermath.

- Well over half (60.1%) of respondents familiar with Nagin rated his performance "fair" or "poor."
  - Nearly 70% of Blanco's ratings fell into these categories, and 92% rated Brown's performance no better than "fair.
  - These results are consistent with the large percentage attributing blame to the Federal government presented in the previous section

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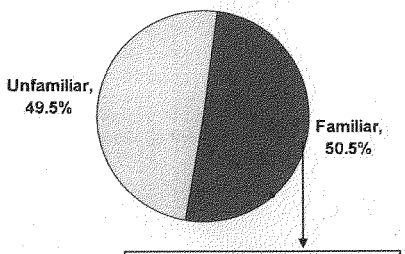
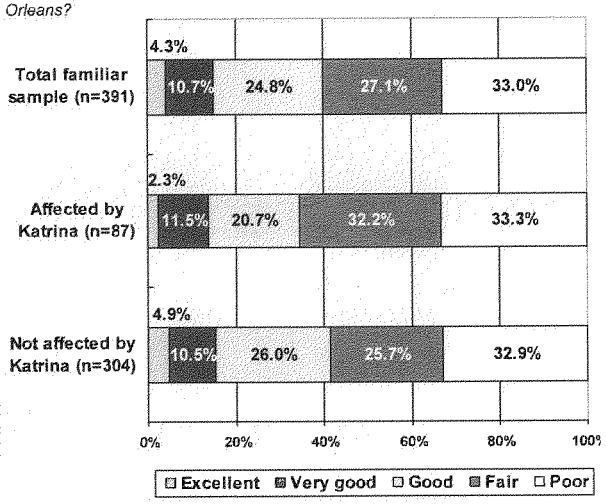
Leader Performance Ratings: Mayor Ray Nagin



Gulf South – 56.0%
Other South – 57.1%
Outside South – 46.2%

•Among respondents who indicated that they were familiar with Ray Nagin, 95% correctly identified him as Mayor of New Orleans.

Question: Based on everything that you have read, heard or experienced since the time Hurricane Katrina hit, how would you rate the job that Ray Nagin has done with regard to the recovery of New Orleans?



•Forty-one percent (41%) of Gulf South residents rated Nagin's performance as "poor."

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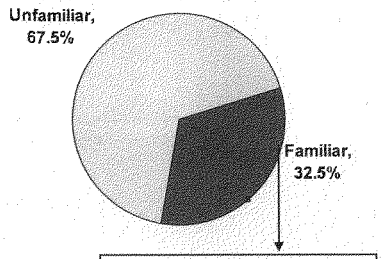
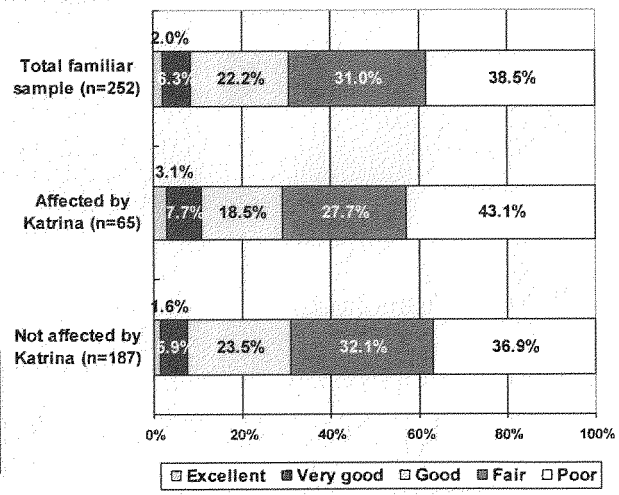
Leader Performance Ratings: Governor Kathleen Blanco



Gulf South – 39.6%
Other South – 38.1%
Outside South – 28.5%

•Among respondents who indicated that they were familiar with Kathleen Babineaux Blanco, 92% correctly identified her as Governor of Louisiana.

Question: Based on everything that you have read, heard or experienced since the time Hurricane Katrina hit, how would you rate the job that Kathleen Babineaux Blanco has done with regard to the recovery of New Orleans?



•Nearly half (49%) of Gulf South residents rated Blanco's performance as "poor."

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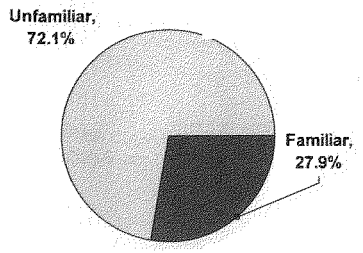
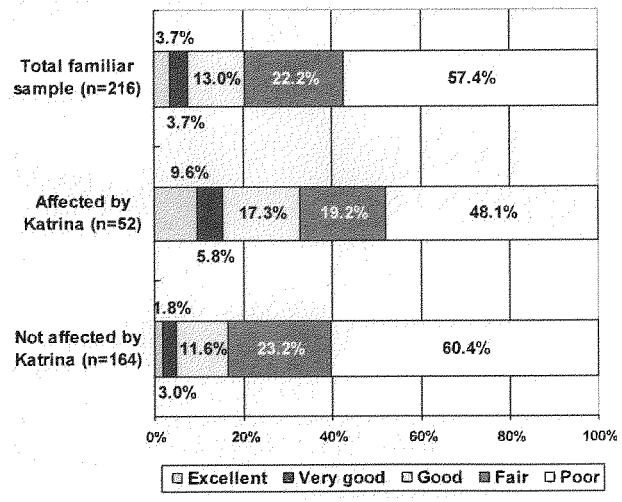
Leader Performance Ratings: Former FEMA Head Michael Brown



•Among respondents who indicated that they were familiar with Michael Brown, 81% correctly identified him as the Director of FEMA at the time of Katrina.

Question: Based on everything that you have read, heard or experienced since the time Hurricane Katrina hit, how would you rate the job that Michael Brown has done with regard to the recovery of New Orleans?



•Respondents who were affected by Katrina were somewhat more positive in their assessment of Brown than those not affected.

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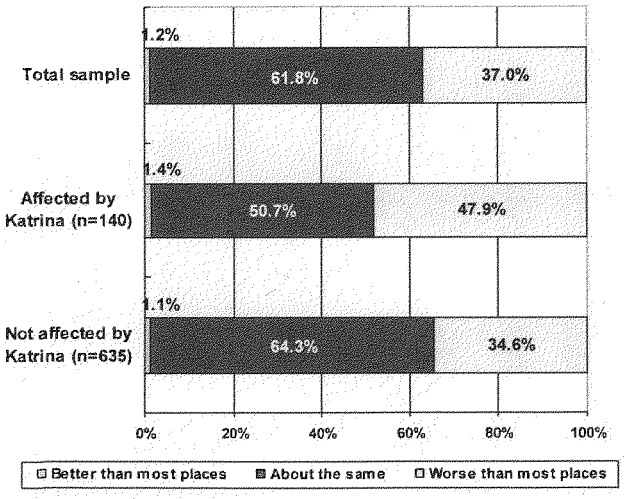
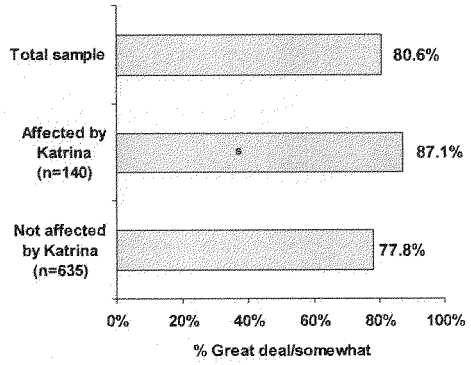
Leader Performance Ratings: Political Corruption

Question: Thinking about both the City of New Orleans and the State of Louisiana, in general, how would you describe the problem of political corruption in the area?



Question: Do you feel that political corruption in the State of Louisiana and City of New Orleans has impeded the post-Katrina recovery effort a great deal, somewhat, a little, not at all?



*Respondents who were affected by Katrina were most likely to consider political corruption worse in Louisiana than in other places around the country and to believe that corruption has impeded the recovery effort.

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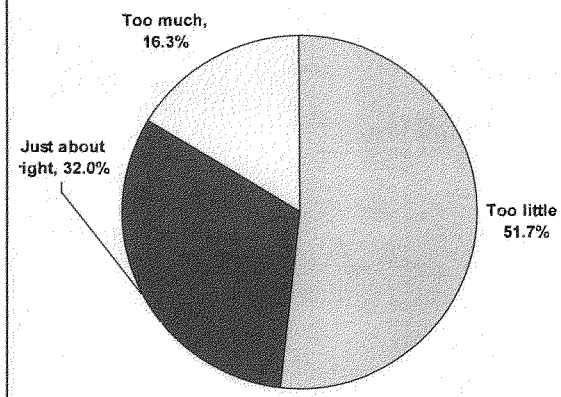
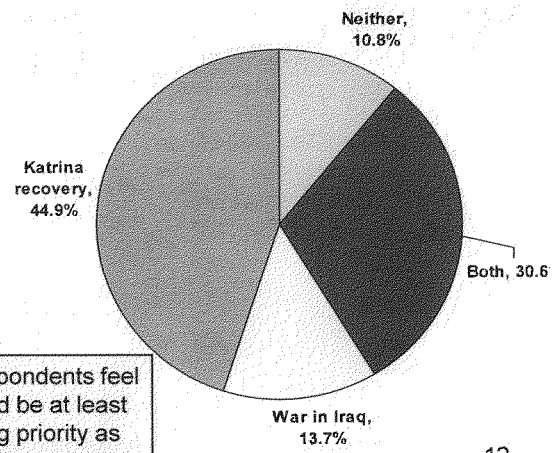
Following the Money

Question: Would you say that the amount of money and other support that the Federal Government has provided the City of New Orleans since Hurricane Katrina has been too much, too little, or just about right?



•The majority of respondents believe that the Federal government has spent too little in support of New Orleans' recovery.

Question: Which of the following should be a greater priority in terms of Federal spending?



•Over three-quarters of respondents feel that Katrina recovery should be at least as great a Federal spending priority as the war in Iraq.

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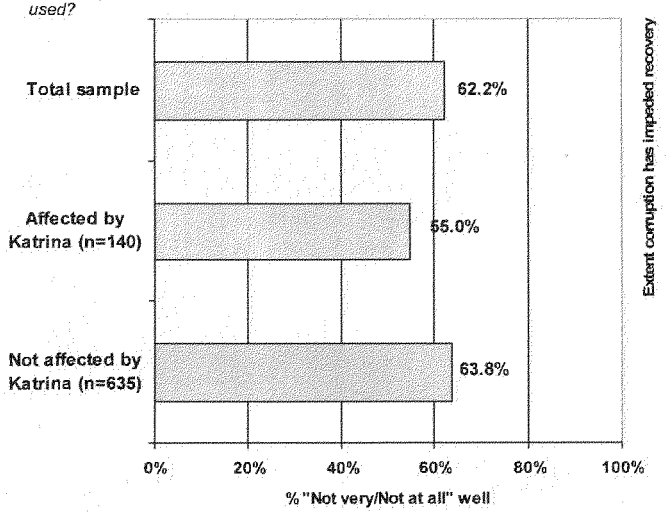
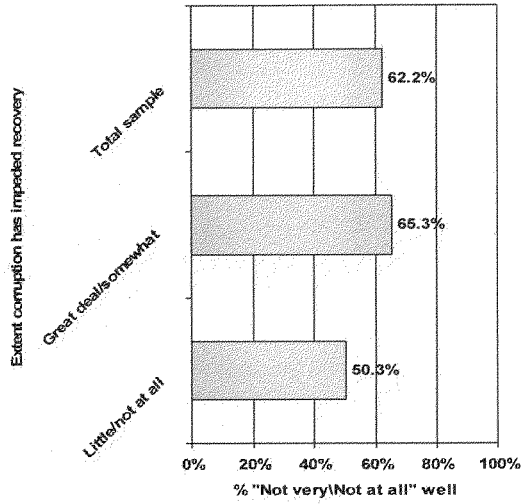
Following the Money

Question: Based on what you know or personally believe, how well do you think that the money that has been spent on Katrina recovery, whether by the Federal Government or private charities, has been used?





•Results suggest that corruption is, to some extent, blamed for poor use of resources devoted to Katrina recovery.

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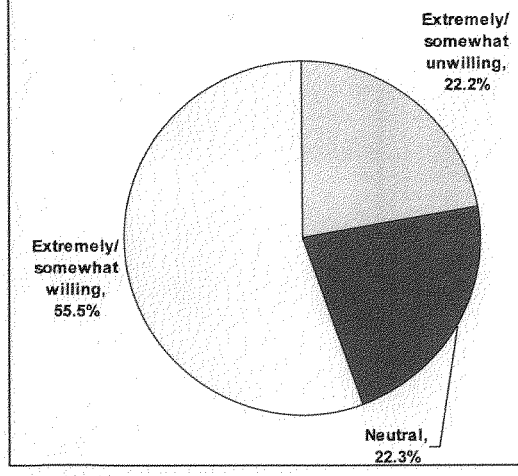
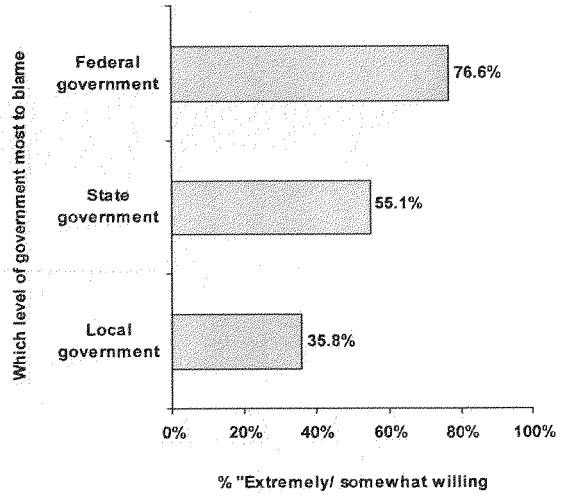
Following the Money

Question: Keeping in mind that all Federal aid involves the expenditure of tax dollars, how willing are you to have the Federal Government continue to provide New Orleans with financial aid aimed at post-Katrina recovery?



•The level of government that respondents feel was most to blame for Katrina problems has much to do with their willingness to continue to support recovery with tax dollars.



•Over half of respondents indicate a willingness to continue to support recovery through Federal tax dollars.

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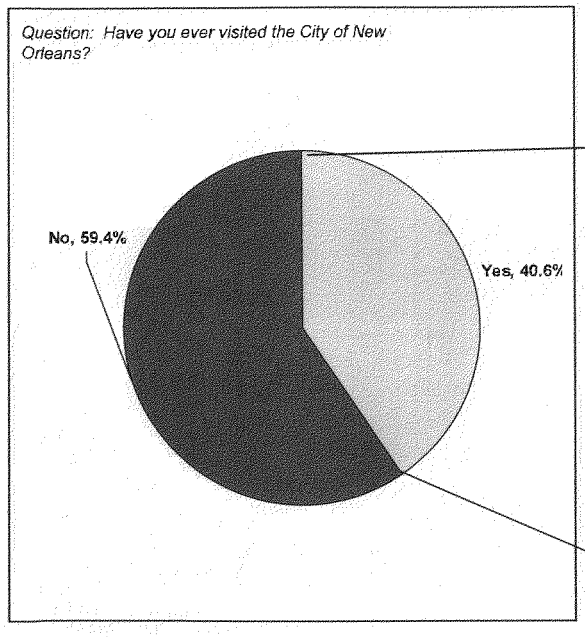
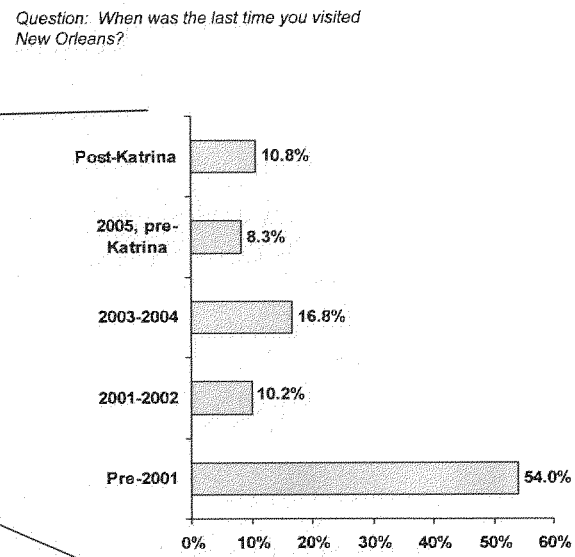
Tourism Prospects





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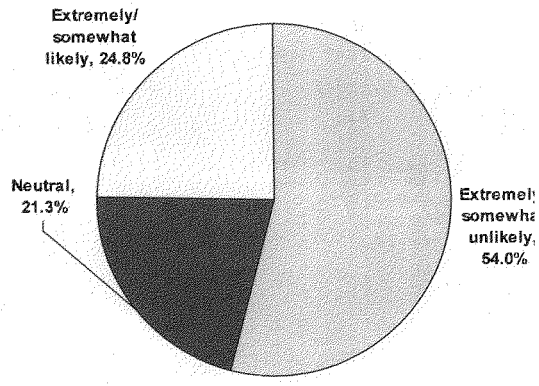
•About 41% of respondents have previously visited New Orleans, about 11% of these have visited since Katrina

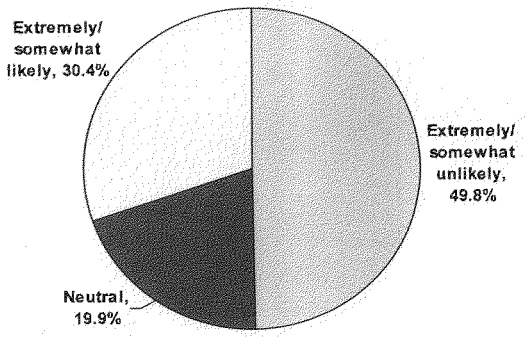
Tourism Prospects

Question: How likely do you think you will be to travel to New Orleans for either business or pleasure purposes over the next 2 years?



•Even among frequent travelers, less than one-third plan to travel to New Orleans over the next 2 years.

Frequent travelers (more than 2 trips per year)



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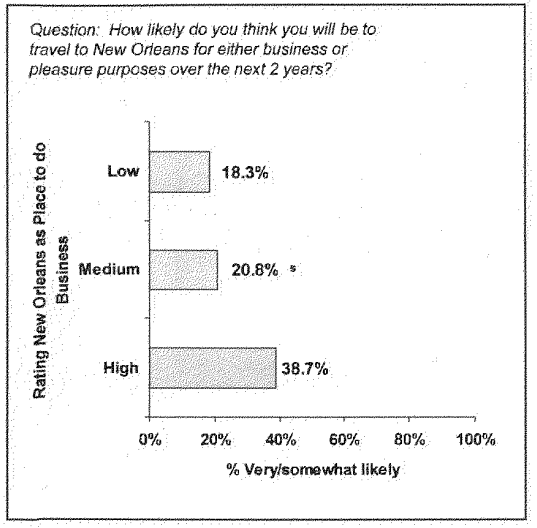
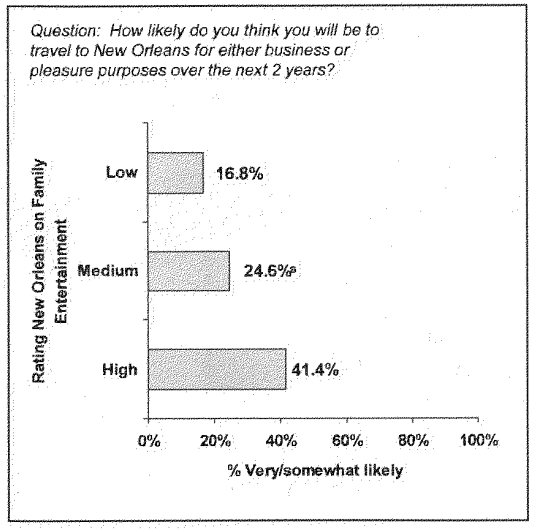
Tourism Prospects





•Respondents' ratings of New Orleans can materially impact their likelihood of visitation.

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